2008
Retiree Benefits Summary

MedicareComplete Retiree Plans

Arizona Department of Administration

SecureHorizons® by UnitedHealthcare

Live Secure. Be Secure.™

Table of Contents

SECTION I: Introduction to MedicareComplete,® a SecureHorizons® Medicare Advantage Retiree Plan

Enroll Today and Live Secure. Be Secure.™

It's time to get all the benefits Medicare has to offer…and more.
With so many options available, we know it can be confusing when it comes to choosing the right health care coverage. That's why SecureHorizons® by United Healthcare provides Medicare Advantage Retiree Plans for the way you live.

SecureHorizons health plans have been helping Medicare beneficiaries manage their health care coverage for over 20 years. And our expertise is available to you through your employer's group health care coverage.

We are focused on providing health plans and services that empower seniors and Medicare beneficiaries to take control of their health care coverage decisions. We believe you should have the freedom of choice: in physicians, in hospitals and especially in health plans. Your SecureHorizons Medicare Advantage Plans offer more benefits than Original Medicare alone, such as predictable monthly premiums, lower out-of-pocket costs, virtually no paperwork — and Part D prescription drug coverage.

More Benefits, More Choices, Expanded Coverage and Convenience

More Benefits — With SecureHorizons Medicare Advantage Plans, you can enjoy benefits that are not covered by Medicare Part A and Part B, including vision, hearing and other health and wellness programs. By choosing the way you receive your Medicare benefits through SecureHorizons health plans, you'll be choosing the benefits that best fit your health care goals, lifestyle and budget.

More Choices — If you're like most people on Medicare, prescription medications probably take a bite out of your budget. With your SecureHorizons health plan, you can take advantage of coverage for more than 1,300 prescription medications and our convenient Mail Service Pharmacy that may lower your prescription drug costs even more.

Expansive Network of Physicians and Hospitals — SecureHorizons Medicare Advantage Plans give you access to nearly any doctor or hospital, which increases your options and choices in accessing the care you need. It's just another example of how we empower you to take control of your health care decisions.

Guide to Enrollment For MedicareComplete® Retiree Plan

The approved Service Area for the ADOA MedicareComplete Retiree Plan includes: Cochise, Coconino, Graham, Greenlee, La Paz, Maricopa, Pima, Pinal, Santa Cruz, Yavapai and Yuma counties.

1. **Please Review the Enclosed Information**
   It contains everything you need to learn more about MedicareComplete Retiree Plan and the different plans we offer to the retirees of the Arizona Department of Administration (ADOA). There is a lot of information contained in this packet, but, as you know, when it comes to health care, it's important to make well-informed decisions.

2. **Refer to the *Summary of Benefits***
   As you consider your needs, refer to this ADOA MedicareComplete Retiree Plan *Retiree Benefit Summary*. It presents a listing of the MedicareComplete Retiree Plan services provided. After reviewing this material, you can determine if the MedicareComplete Retiree Plan product is the right health coverage for you.

3. **Choose Your Primary Care Physician**
   Please refer to the booklet entitled *Provider Directory* for a complete listing of the contracted Hospitals, Physicians and associated services. There are three ways to select a PCP: geographically, if you're looking for a Primary Care Physician (PCP) in a convenient area; hospital preference, if you would like to use a specific Hospital; or Physician preference, if you have a specific Physician you prefer to use. Your PCP may be a family practitioner, general practitioner or an internist.

4. **Complete the Enrollment Form**
   Having determined the MedicareComplete Retiree Plan that meets your needs, and having selected a network and PCP, you are now ready to complete the ADOA enrollment form. These forms are available in this enrollment packet or from ADOA.

5. **Complete the Statement of Understanding if You or Your Dependent(s) is/are Medicare-Entitled**
   The Statement of Understanding (SOU) is the next form to complete. It is required by the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, to demonstrate that you understand how MedicareComplete Retiree Plan works and the benefits that your plan provides. This is a four (4)-part form, so it is important that you press firmly when completing it. Each Medicare-entitled family member must sign and date the SOU.

6. **Return the Forms**
   Now mail these forms to the Arizona Department of Administration. Remember, if you or any family member is Medicare-entitled, you will need to return both the ADOA Enrollment Form and the completed SOU.

Eligibility and Enrollment in the MedicareComplete Retiree Plan

To be able to enroll in MedicareComplete Retiree Plan:

1. You must be entitled to Medicare Part A and enrolled in Medicare Part B. You must be enrolled in Medicare Part A and Medicare Part B as of the Effective Date of your enrollment in MedicareComplete Retiree Plan.

2. You must meet the eligibility requirements of the Arizona Department of Administration.

3. You must not currently have End-Stage Renal Disease (ESRD) or receive routine kidney dialysis. However, if either of these conditions should apply to you, in some instances, you may still be eligible to enroll through a plan-sponsored Medicare Advantage (MA) health plan or as an individual. You may be newly eligible for enrollment or able to continue your enrollment under the following circumstances:

   - Individuals with ESRD who age into Medicare can enroll in any Medicare Advantage Plan sponsored by their plan sponsor regardless of prior

commercial coverage affiliation (your health plan coverage prior to you becoming eligible for Medicare).

- If a plan sponsor offers a Medicare Advantage Plan as a new option to its employees and retirees, regardless of whether it has been an option in the past, retirees with ESRD may select this new Medicare Advantage Plan option as the plan sponsor's open enrollment rules allow. You should contact your plan sponsor to determine what their rules allow.
- If a plan sponsor that has been offering a variety of coverage options consolidates its employee/retiree offerings (for example, it drops one or more plans), current enrollees of the dropped plans may be accepted into a Medicare Advantage Plan that is offered by the group.
- If a plan sponsor has contracted locally with a Medicare Advantage Organization in more than one geographic area (for example, in two or more states), a retiree with ESRD who relocates permanently from one geographic location to another may remain with the Medicare Advantage Organization in the local plan-sponsor Medicare Advantage Plan.
- Individuals with ESRD who are affected by the contract termination, non-renewal or Service Area reduction of another Medicare Advantage Organization may make one election to enroll in a Medicare Advantage plan offered by a different Medicare Advantage Organization during the appropriate election period.
- Once enrolled in a Medicare Advantage plan, an individual with ESRD may elect other Medicare Advantage plans offered by the same Medicare Advantage Organization (within the same CMS contract) during an allowable election period. Standard Medicare Advantage eligibility rules apply.

Note: *If you have received a transplant that has restored your kidney function and you no longer require a regular course of dialysis, you are not considered to have ESRD and you are eligible to enroll in the MedicareComplete® Retiree Plan.*

4. You must permanently reside in the Service Area as defined in your Evidence of Coverage and Disclosure Information.
5. You must complete and sign an Enrollment Application Form or make an election through your Plan Sponsor. If another person assists you in completing the Enrollment Application Form, that person must also sign the form and state his or her relationship to you.
6. You must agree to abide by the MedicareComplete Retiree Plan rules (included in this Retiree Benefits Summary book, your Evidence of Coverage and Disclosure Information and throughout your member materials).

If you meet the above eligibility requirements, you cannot be denied membership in MedicareComplete Retiree Plan on the basis of your health status, excluding end-stage renal disease as described above.

When You May Enroll in the MedicareComplete Retiree Plan

Eligible individuals can enroll in the MedicareComplete Retiree Plan at the following times:

- Open Enrollment — You may enroll in your plan sponsor's group plan when that plan is in open enrollment. This time period is typically around the end of the calendar year but it can vary. For more information regarding your open enrollment period, please contact your plan sponsor.
- Special Election Period (SEP) — Special periods of time in which you can discontinue enrollment in a Medicare Advantage Plan, and change your enrollment to another Medicare Advantage Plan or return to Medicare. In the event of the following circumstances, a Special Election Period is warranted: the Medicare Advantage Plan in which you are enrolled is discontinued in the Service Area in which you live; you move out of the Service Area of the Medicare Advantage Plan; the Medicare Advantage Organization offering the plan violated a material provision of its contract with you; or you meet such other material conditions as CMS may provide.

As a MedicareComplete Retiree Plan Member, the information below does not apply to you because you are allowed to make enrollment changes at times designated by your Plan Sponsor (see above). However, if you ever choose to discontinue your plan-sponsored health care coverage, the information below (up to Medicare Part D Late Enrollment Penalty) will apply to you.

In general, there are only certain times during the year when you can change the way you get your Medicare coverage. There are also Medicare program limits on how often you can make a change to your Medicare coverage and what types of changes you are allowed to make.

Note: Certain eligible Medicare beneficiaries, such as those who are institutionalized, those who receive Medicaid, or those eligible for a Medicare Savings Program such as Medicaid Qualified Medicare Beneficiary, Special Low Income Medicare Beneficiary, Qualified Disabled Working Individual or a Qualified Individual may enroll in MedicareComplete Retiree Plan at any time during the Calendar Year.

For Medicare beneficiaries who currently have Medicare coverage, the following dates are important:

From November 15, 2007 through December 31, 2007, anyone with Medicare may change the way they get their Medicare coverage for an effective date of **January 1, 2008.**

Medicare beneficiaries who are enrolled in a Medicare Part D plan who want to keep their Medicare Part D drug coverage have the following options:

- You may leave your current Medicare Advantage Plan with Medicare Part D drug coverage and enroll in another Medicare Advantage Plan with Medicare Part D drug coverage, such as MedicareComplete Retiree Plan.
- You may leave your current Medicare Advantage Plan with Medicare Part D drug coverage and enroll in a Prescription Drug Plan and return to Original Medicare coverage.

- You may leave your current Prescription Drug plan and enroll in another Prescription Drug plan in addition to Original Medicare.

Medicare beneficiaries who are enrolled in a Medicare Part D plan and who do **not** want to keep their Medicare Part D drug coverage have the following options:

- You may leave your current Medicare Advantage Plan with Medicare Part D drug coverage and enroll in a "medical only" Medicare Advantage Plan, such as MedicareComplete Retiree Plan, without Medicare Part D drug coverage.
- You may leave your current Medicare Advantage Plan with Medicare Part D drug coverage and return to Original Medicare.
- You may leave your current Prescription Drug plan and continue with Original Medicare coverage.
- You may leave your current Prescription Drug plan and enroll in a "medical only" Medicare Advantage Plan, such as MedicareComplete Retiree Plan, without Medicare Part D drug coverage.

Medicare beneficiaries who are not enrolled in a Medicare Part D plan and who want to enroll in a Medicare Part D plan have the following options:

- You may leave your current Medicare Advantage Plan without Medicare Part D drug coverage and enroll in another Medicare Advantage Plan with Medicare Part D drug coverage.
- You may leave your current Medicare Advantage Plan without Medicare Part D drug coverage and enroll in a Prescription Drug plan and return to Original Medicare coverage.
- You may enroll in a Prescription Drug plan with Original Medicare coverage.
- You may leave Original Medicare and enroll in a Medicare Advantage Plan with Medicare Part D drug coverage.

From January 1, 2008 through March 31, 2008, Medicare beneficiaries (including Members of the MedicareComplete Retiree Plan) have **one** chance to change the way they get their health care coverage. However, there are limits on when you may change benefit plans and the type of plan that you may join. **If you are not enrolled in a plan with Medicare Part D drug coverage, you may not use this time period to enroll in a plan with Medicare Part D drug coverage.**

Medicare beneficiaries who are enrolled in a Medicare Part D plan have the following options:

- You may leave your current Medicare Advantage Plan with Medicare Part D drug coverage and enroll in another Medicare Advantage Plan with Medicare Part D drug coverage.
- You may leave your current Medicare Advantage Plan with Medicare Part D drug coverage and enroll in a Prescription Drug plan and return to Original Medicare coverage.
- You may leave your current Prescription Drug plan and enroll in a Medicare Advantage Plan with Medicare Part D drug coverage.

Medicare beneficiaries who are **not** enrolled in a Medicare Part D plan have the following options:

- You may leave your current Medicare Advantage Plan without Medicare Part D drug coverage and enroll in another Medicare Advantage Plan without Medicare Part D drug coverage.
- You may leave your current Medicare Advantage Plan without Medicare Part D drug coverage and return to Original Medicare.
- If you currently have Original Medicare, you may enroll in a Medicare Advantage Plan without Medicare Part D drug coverage.

Generally, Medicare beneficiaries cannot make any other changes during 2008 unless they meet special exceptions, including, but not limited to:

- the Medicare Advantage Plan in which the beneficiary is enrolled is discontinued in the Service Area in which the beneficiary lives
- the beneficiary moves out of the Service Area of the Medicare Advantage Plan
- the beneficiary meets such other material conditions as CMS may provide (as a result of unusual and/or out-of-the-ordinary circumstances such as natural disasters, etc.)
- the beneficiary has Medicaid coverage
- the beneficiary receives assistance from a Medicare Savings Program
- the beneficiary is in a long-term care facility such as a nursing home

If you are a Medicare beneficiary who is newly eligible for Medicare coverage:

You may elect to enroll in a Medicare Advantage Plan when you first become entitled to both Part A and Part B of Medicare. Your enrollment period begins on the first day of the third month before the date on which you are entitled to both Part A and Part B, and ends on the last day of the third month after the date on which you become eligible for both Parts of Medicare. For example: if you are eligible for both Part A and Part B on September 1, you may enroll in MedicareComplete as early as June 1, but not later than August 31, for a September 1 Effective Date.

Medicare Part D Late Enrollment Penalty

You will be assessed a penalty by the Federal government when you enroll in Medicare Part D if you did not enroll in a Medicare Part D drug plan during your initial enrollment period and you did not have creditable coverage for a continuous period of 63 days or more after your initial enrollment period. Creditable prescription drug coverage is coverage that is at least as good as the standard Medicare Part D prescription drug coverage. You pay this late enrollment penalty for as long as you have Medicare Part D prescription drug coverage. The amount of the penalty may increase every year.

The late enrollment penalty also applies to individuals who qualify for extra help with their drug plan costs. However, Medicare helps pay for the penalty for individuals who qualify for the most help. People who qualify for the most help will pay 20% of the penalty for the first 60 months and none of the penalty afterwards.

Creditable Coverage

Both of the MedicareComplete Retiree Plans provided through ADOA include a Medicare Part D prescription drug plan. Please refer to your Retiree Benefits Summary and Insert to determine your coverage. Medicare Part D prescription drug coverage is considered to be *Creditable Coverage*.

If your Plan Sponsor does not offer you Medicare Part D prescription drug coverage, but the prescription drug coverage you receive through your Plan Sponsor is at least as good as the standard Part D Medicare prescription drug coverage, it is considered to be *Creditable Coverage* and you will NOT incur a late enrollment penalty if you later decide after May 15, 2006 to enroll in a standard Part D Medicare prescription drug coverage plan. Your plan administrator is responsible to notify you if your prescription drug coverage is or is not considered to be *Creditable Coverage*. If you have questions about your prescription drug coverage, please contact your Plan Sponsor.

If your prescription drug coverage is not considered to be *Creditable Coverage*, you will have to pay a penalty if you do not enroll in a Medicare Part D drug plan during your initial enrollment period and you do not have creditable coverage for a continuous period of 63 days or more after your initial enrollment period. See the *Medicare Part D Late Enrollment Penalty* section above for more information.

If you purchase a Medicare Part D prescription drug plan on your own, it could result in the loss of your medical coverage provided through the MedicareComplete Retiree Plan and could affect your plan-sponsored health benefits. It is important to read the communications your plan sponsor (plan administrator) sends you, and consult with them before you take any action.

More detailed information about Medicare plans that offer prescription drug coverage is available in the *Medicare & You 2008* handbook. You'll get a copy of the handbook in the mail from Medicare in the fall season. You can also get more information about Medicare prescription drug plans from these places:

- Visit *www.medicare.gov* for personalized help;
- Call your State Health Insurance Assistance Program (see your copy of the *Medicare & You* handbook for their telephone number);
- Call **1-800-MEDICARE (1-800-633-4227),** (for the hearing impaired, **1-877-486-2048**), 24 hours a day, 7 days a week.

Your Enrollment Application Form

Once you complete and sign an Enrollment Application Form, or make an election through your Plan Sponsor and complete the Statement of Understanding, this information is submitted to CMS for verification of eligibility in the MedicareComplete Retiree Plan. If CMS rejects your Enrollment Application Form or election through your Plan Sponsor, we will contact you for additional information or provide you with instructions for resubmitting the Enrollment Application Form or election through your Plan Sponsor.

When Your MedicareComplete Retiree Plan Coverage Begins

The Effective Date of enrollment in MedicareComplete Retiree Plan will be determined by your Plan Sponsor. MedicareComplete Retiree Plan will send you a letter that informs you when your coverage begins.

From your Effective Date forward, you must receive all Covered Services from Contracting Medical Providers. Neither SecureHorizons nor Medicare will pay for services received from Non-Contracting Medical Providers, except for:

- Emergency Services anywhere in the world
- Urgently Needed Services that were not foreseeable when you left the Service Area
- Out-of-area renal dialysis services and routine travel dialysis (must be received at a Medicare Certified Dialysis Facility within the United States)
- Referrals that have received Prior Authorization

If you receive any medical services not covered by Medicare before your MedicareComplete Retiree Plan coverage takes effect, you are financially responsible for those services.

Our Liability upon Your Initial Enrollment

- We are responsible for the full scope of Part B services, as required by Medicare, beginning on your Effective Date. However, if your Effective Date occurs during an inpatient stay in a Hospital, we are not responsible for arranging or paying for any of the inpatient Hospital services under the Medicare Hospital Insurance Plan (Part A). We must assume responsibility for arranging or paying for inpatient Hospital services under the Medicare Hospital Insurance Plan (Part A) on the day following the day of discharge.

Information Regarding Medicare Supplement (Medigap) Policies

After you receive written confirmation from us of your effective date for coverage through MedicareComplete, you may consider canceling any Medicare supplement (Medigap) policy you may have. If you currently have a Medigap policy with prescription drug coverage, you must inform your Medigap issuer you have enrolled in our plan. Medigap policies do not reimburse you for Health Plan Premiums, Copayments, or other amounts that Medicare Advantage Plans charge for Medicare-covered services. However, if you Disenroll from MedicareComplete, you may **not** be able to have your Medigap policy reinstated and you **will not,** under any circumstances, be able to have your Medigap policy with prescription drugs reinstated.

Note: In certain cases, you may be guaranteed issue (without medical underwriting or pre-existing condition exclusions) of a Medicare supplemental (Medigap) policy.

You must apply for a Medigap policy within sixty-three (63) days after your MedicareComplete Retiree Plan coverage terminates and submit evidence of the date of your loss of coverage. For additional information regarding guaranteed Medicare supplemental policies, please call **1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048),** 24 hours a day, 7 days a week.

Should you choose to keep your Medicare supplement (Medigap) policy, you may not be reimbursed for services you receive from Non-Contracting Medical Providers. Most supplemental (Medigap) policies will not pay for any portion of such services because:

- Supplemental insurers (Medigap insurers) process their claims based on proof of an Original Medicare payment, usually in the form of an Explanation of Medicare

Benefits (EOMB). However, as long as you are a Member of MedicareComplete Retiree Plan, Original Medicare will not process any claims for medical services that you receive.

- We have the financial responsibility for all Medicare-covered health services you need as long as you follow MedicareComplete Retiree Plan procedures on how to receive medical services.

Some states provide additional Medigap protections. For State specific information, please call Customer Service, your State's Department of Insurance or your State Health Insurance Assistance Program (SHIP).

Your Plan. Your Doctor. Your Choice.

Your SecureHorizons Physician Network

We are focused on providing health plans and services that empower seniors and other Medicare beneficiaries to take control of their health care coverage decisions. We believe you should have the freedom of choice, especially in physicians and hospitals.

When you enroll in a MedicareComplete Retiree Plan, you can choose from a large network of physicians, health care professionals and hospitals within your community. Our provider networks change periodically. In fact, your personal health care professional is probably already in our network.

Most of the Care You Need — Where You Need It

To find the appropriate physician and other health care professionals, visit our Web site at *www.securehorizons.com* and click on the "Find a Physician" link to find someone in your area. This online resource provides easy access to information about your primary care providers and specialists, including their specific office location. Please note that our provider networks change periodically.

Preventive Care Beyond What Original Medicare Covers

You need a health plan you can rely on — whether you have just become Medicare eligible, you're on another Medicare Advantage Plan, or you're currently relying on Original Medicare. The MedicareComplete Retiree Plan is currently one of the largest Medicare Advantage Plans in the United States. We give you a more comprehensive range of health care benefits than you get with Original Medicare alone. And while we don't try to be all things to all people, we do believe that the MedicareComplete Retiree Plan helps many Medicare beneficiaries remain healthy and independent.

Choose A Respected, Local Physician To Coordinate Your Care

If you join MedicareComplete Retiree Plan,you agree to use contracting medical providers and to have your health care arranged through your primary care physician. He or she will coordinate your medical care personally, guiding you to specialists and other contracting medical providers, as necessary. You'll pay an office visit copayment when you visit your contracting medical provider. You can select your primary care physician from the provider directory — you may choose a family practice, general practice or internal medicine physician.

Your Primary Care Physician (PCP)

When you join MedicareComplete Retiree Plan,you agree to a "Lock-in" feature that says you will receive all your medical services through a primary care physician, except for emergency services, urgently needed services, out-of-area renal dialysis and routine travel renal dialysis or covered services for which MedicareComplete Retiree Plan allows you to self-refer to contracting medical providers. Your covered services must be provided or authorized by your primary care physician or contracting medical group/IPA. This is a typical feature of some Medicare Advantage Plans. If you go outside our health plan for routine care or any unauthorized service, neither MedicareComplete nor Medicare will pay for your costs. To change your primary care physician, simply call or write our Customer Service Department for assistance.

What Happens If I Go To a Doctor Who is Not a Network Provider?

If you choose to go to a doctor outside of our network, you must pay for these services yourself. Neither MedicareComplete nor the Original Medicare Plan will pay for these services.

Access To OB/GYN Physician Services And Women's Routine And Preventive Health Care Services

Women may self-refer to a women's health specialist (for example, OB/GYN) within our network/contracting medical group/IPA for covered annual routine and preventive services as described in Section II of this book. Also, women ages 40 and over may self-refer annually to a mammography-screening provider within our network/contracting medical group/IPA. Your primary care physician must approve any OB/GYN inpatient or hospital services, except emergency or urgently needed services.

Specialist Referrals

Your primary care physician is trained to handle the majority of common health care needs. However, there may be a time when your primary care physician feels you need specialized treatment. Then, he or she may refer you to a specialist. Neither MedicareComplete nor Medicare will pay for services, procedures, treatments, surgeries and/or drug therapies for which a referral is required, but was not obtained from your contracting medical provider, except for emergency or urgently needed services.

We'll Cover You When You Need Emergency Or Urgent Care, Whether You're Out of Town or Out of the Country

Emergency and urgently needed services never require prior authorization. No matter where you are in the world, you'll be covered in these cases for each Medicare-covered visit (Emergency and urgently needed services copayments may apply and may vary). However, **be sure to contact your primary care physician or our Customer Service at the number located on your membership card or on the back cover of this booklet within forty-eight (48) hours, or as soon as reasonably possible,** so they can help coordinate any follow-up care you may need.

Emergency Medical Condition

This is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Placing the member's health in serious jeopardy; serious impairment to bodily functions;
2. serious dysfunction of any bodily organ or part.
3. In the case of a pregnant woman, an Emergency Medical Condition exists if the member is in Active Labor, meaning labor at a time in which either of the following would occur: a) there is inadequate time to effect safe transfer to another hospital prior to delivery; or b) a transfer may pose a threat to the health and safety of the member or the unborn child.

Post-Stabilization Care

Medically necessary, non-emergency services following receipt of emergency care to enable you to remain stabilized are covered when:

- SecureHorizons or its contracting medical providers give prior authorization for such services;
- SecureHorizons or its contracting medical providers do not respond within one (1) hour to a request for a prior authorization from a non-contracting provider or facility; or
- SecureHorizons or its contracting medical providers could not be contacted for prior authorization.

Coverage for post-stabilization care provided by a non-contracting provider continues to be covered until one of the following:

- You are discharged.
- A contracting medical provider arrives and assumes responsibility for your care.
- The non-contracting provider and SecureHorizons agree to other arrangements; or
- a contracting medical provider assumes responsibility for your care through the transfer to a contracting facility.

Urgently Needed Services

Urgently needed services are covered services provided when you are temporarily* absent from the MedicareComplete Medicare Advantage Service Area, and the services cannot be delayed until you return to the Service Area (or, under unusual and extraordinary circumstances, you are in the Service Area, but your contracting medical group/IPA/network is temporarily unavailable or inaccessible), when such services are medically necessary and immediately required:

- as a result of an unforeseen illness, injury, or condition,
- and it is not possible, given the circumstances, to receive services through your primary care physician.

* *A temporary absence is an absence from the Service Area lasting not more than six months and it is not a permanent move.*

SECTION II: Your MedicareComplete® Retiree Plan Benefits — High Option (through a network medical provider)

Summary of MedicareComplete Retiree Plan High Option Benefits

Effective Date: 1/1/2008 to 12/31/2008

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Physician Services	
■ Primary Care Physician	$10 copayment per office visit
■ Specialist	$10 copayment per office visit
Emergency Department Services	
■ Within and Outside of the United States	$50 copayment; waived if admitted to the hospital
Urgently Needed Care	
■ Primary Care Physician	$20 copayment per visit
■ In-area/in-network provider other than primary care physician	$20 copayment per visit
■ In-area/non-network provider or out-of-area provider	$20 copayment per visit
Ambulance Services	Covered in Full per Medicare-covered trip
Inpatient Care	
Inpatient Hospital Care (Including Transplants)	Covered in Full per admission for unlimited days as medically necessary
Inpatient Mental Health Care	Covered in Full per admission; 190-day lifetime maximum
Skilled Nursing Facility Care	Covered in Full; maximum one hundred (100) days per benefit period
Other Settings	
Home Health Agency Care	Covered in Full
Hospice	Reimbursed directly by Medicare; refer to *Medicare & You* handbook
Outpatient Medical Services and Supplies	
Outpatient Mental Health Care	$10 copayment per office visit
Partial Hospitalization Psychiatric Program	Covered in Full per admission

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Outpatient Substance Abuse Services	$10 copayment per office visit
Outpatient Surgery and Services	Covered in Full per surgery
Outpatient Hospital Services	Covered in Full per visit
Medicare-covered Outpatient Rehabilitation Services	$10 copayment per office visit
Durable Medical Equipment (DME)	Covered in Full
Diabetes Self-Management Training	Covered in Full
Diabetes Self-Monitoring Supplies	Covered in Full
Medical Nutrition Therapy	Covered in Full
Imaging Procedures, X-rays and Portable X-rays Used in the Home	
■ Medicare-covered Standard X-rays	Covered in Full
■ Complex Radiology Services and Imaging Procedures	Covered in Full
Laboratory Services	Covered in Full
Radiation Therapy	Covered in Full
Medical Supplies	Covered in Full
Blood and Its Administration	Covered in Full
Kidney Dialysis	Covered in full at a network facility or at a Medicare-certified facility within the United States
Preventive Services	
Bone Mass Measurement	Covered in Full
Colorectal Screening Exams	Covered in Full
Annual Screening Mammograms	Covered in Full
Well-Woman Care/Pap Smears and Pelvic Exams	$10 copayment per visit.
Annual Prostate Cancer Screening Exams	Covered in Full
Cardiovascular Disease Testing	$10 copayment per office visit

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Immunizations	
Immunizations	
■ Pneumococcal Pneumonia Vaccine	Covered in Full
■ Flu Vaccine	Covered in Full
■ Hepatitis B Vaccine	Covered in Full
Part B Prescription Drugs	
Medicare Part B Covered Prescription Drugs	
■ Immunosuppressive Drugs	Covered in Full
■ Chemotherapy Drugs including Anti-nausea Drugs	Covered in Full
■ Inhalation Solutions	Covered in Full
Outpatient Injectable Medications	
■ Self-Administered	Covered in Full
■ Administered in a Physician's Office	Covered in Full
■ Home Health	Covered in Full
Hemophilia Clotting Factors	
■ Self-Administered	Covered in Full
■ Administered in a Physician's Office	Covered in Full
■ Home Health	Covered in Full
Antigens	Covered in Full
Allergy Testing	$10 copayment per visit
Additional Benefits	
Chiropractic Services	
■ Medicare-covered	$10 copayment per office visit
■ Routine	Not Covered
Dental Services	
■ Medically Necessary Services	$10 copayment per office visit
■ Routine	Not Covered
Foot Care	
■ Medicare-covered	$10 copayment per office visit
■ Routine	Not Covered

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Hearing Services	
■ Medicare-covered Diagnostic Hearing Examination	$10 copayment per visit
■ Routine Hearing Examination for Hearing Aids	$10 copayment per visit
■ Hearing Aids	$1,000 allowance per calendar year
Vision Care Services	
■ Medicare-covered Eye Exam	$10 copayment per visit
■ Medicare-covered Eyewear or Contact Lenses	Covered in Full
Routine Eye Exam and Eyewear or Contact Lenses	
■ Routine Eye Exam	$10 copayment; one exam per year
■ Routine Eyewear or Contact Lenses	$50 Frames and Lenses allowance every 12 months or $50 allowance for Contact Lenses every 12 months
Annual Routine Physical Examinations (non Medicare-covered)	Medicare initial preventive physical exam covered in full; $10 copayment for annual routine physical examination
Optum® NurseLine	You pay $0 for calls to the NurseLine, available 24 hours a day, every day, to help you with health and medical questions. Simply call 1-877-365-7949, or for the hearing impaired, call the National Relay Center at 1-800-855-2880 and ask for 1-877-365-79510.
Out-of-Pocket Maximum	None
Part D — Outpatient Prescription Drugs	
$0 – $4,050 Out-of-Pocket Costs	
Retail	You pay a $7 copayment for Tier I preferred generic drugs. You pay a $20 copayment for Tier II preferred brand name drugs. You pay a $20 copayment for Tier III non-preferred drugs. You pay a $20 copayment for Tier IV specialty drugs per Prescription Unit or up to a 30-day supply.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Mail Service	You pay a $14 copayment for Tier I preferred generic drugs. You pay a $40 copayment for Tier II preferred brand name drugs. You pay a $40 copayment for Tier III non-preferred drugs. You pay a $40 copayment for Tier IV specialty drugs per up to a 90-day supply through our contracted Mail Service Pharmacy.
After Your Yearly Out-of-Pocket Costs Reach: $4,050	You pay the greater of $2.35 for generic or a preferred brand drug that is a multi-source drug, and $5.60 for all other drugs, or 5% coinsurance once your total out-of-pocket costs reach $4,050.
Your MedicareComplete Retiree Plan Benefits	
Health Plan Premium	In most cases, your plan sponsor is responsible for making payment of any applicable Health Plan Premium directly to SecureHorizons® on behalf of its enrolled MedicareComplete Retiree Plan Members and their eligible dependent(s). Your Plan Sponsor determines the amount of any retiree subscriber contribution toward Health Plan Premiums. Some Plan Sponsors, however, have made arrangements with SecureHorizons to bill you, the Member, directly for Health Plan Premiums. If this is the case, your monthly Health Plan Premium is due on the first day of each month for the prior month's coverage. Refer to the ADOA Enrollment Guide for your Monthly Health Plan Premium amount.
Doctor and Hospital Choice	You must go to network doctors, specialists and hospitals. You need a referral to go to network specialists. You need prior authorization to go to non-network doctors, specialists or hospitals.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Physician Services	**Consultation, diagnosis and treatment by a network primary care physician, or under certain circumstances, treatment by a nurse practitioner or physician's assistant. You pay the same copayment for a Coumadin clinic visit under a physician's supervision.** You pay a $10 copayment for each office visit. **Second opinion by another network medical provider for a recommended procedure and/or service.** You pay a $10 copayment for each second opinion with a primary care physician. **Consultation, diagnosis and treatment by a specialist for a recommended procedure and/or service.** You pay a $10 copayment for each visit with a specialist. **Inpatient physician services, including medical, surgical, psychiatric and skilled nursing care.** You pay a $0 hospitalization copayment per admission.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Emergency Department Services (You may go to any hospital-based emergency department for emergency care.)	Emergency services covered include inpatient or outpatient services that are: 1) furnished by a provider qualified to furnish emergency services, and 2) needed to evaluate or stabilize an emergency medical condition. An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1. placing your health in serious jeopardy; serious impairment to bodily functions; 2. serious dysfunction of any bodily organ or part. 3. In the case of a pregnant woman, an Emergency Medical Condition exists if the member is in Active Labor, meaning labor at a time in which either of the following would occur: a) there is inadequate time to effect safe transfer to another hospital prior to delivery; or b) a transfer may pose a threat to the health and safety of the member or the unborn child. You pay $50 for each Medicare-covered emergency room visit (within and outside of the United States); this amount is waived if you are admitted to the hospital for the same condition. You pay a $0 hospitalization copayment per admission. Post-stabilization services are included. Post-stabilization services are medically necessary, non-emergency services to ensure that you remain stabilized from the time a non-network medical provider or facility requests authorization from us until: 1. you are discharged 2. a network medical provider arrives and assumes responsibility for your care 3. the non-network medical provider and we agree to other arrangements 4. a contracting provider assumes responsibility for your care through the transfer to a contracting facility. Members should notify their network primary care physician or us within 48 hours, or as soon as possible after receiving emergency and urgently needed services.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Urgently Needed Care	Urgently needed covered services include services provided when a) you are temporarily absent from the area serviced by your network provider, and the services cannot be delayed until you return to the Service Area, or b) you are within the Service Area but your network provider or other contracted provider is unavailable or inaccessible, and services cannot be delayed until your network provider or other contacted provider becomes available. You pay a $20 copayment for each Medicare-covered visit with your primary care physician during regular office hours. You pay a $20 copayment for each Medicare-covered visit with an in-area/in-network provider, other than your primary care physician before or after regular office hours. You pay a $20 copayment for each Medicare-covered visit with an in-area/non-network provider or from an out-of-area provider. Services received from an in-area/non-network provider are covered only under unusual and extraordinary circumstances, such as covered services provided when you are in your Service Area, but your network is temporarily unavailable or inaccessible, and when such services are medically necessary and immediately required: 1) as a result of an unforeseen illness, injury or condition and 2) it is not possible, given the circumstances, to receive services through your network provider. You pay these amounts even if you are admitted to the hospital for the same condition. Includes dialysis for acute kidney failure. Post-stabilization services are included. Post-stabilization services are medically necessary, non-emergency services to ensure that you remain stabilized from the time a non-network medical provider or facility requests authorization from us until: 1. you are discharged 2. a network medical provider arrives and assumes responsibility for your care 3. the non-network medical provider and we agree to other arrangements 4. a contracting provider assumes responsibility for your care through the transfer to a contracting facility. Worldwide coverage.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Ambulance Services (Air, water or ground transportation.) Medical necessity limitations apply.	You pay a $0 copayment per Medicare-covered ambulance trip. Member-initiated ambulance transportation for reasons not primarily medical in nature, and which serve only as a convenience to the member and/or the member's family, are not covered. Examples include, but are not limited to: 1. geographic relocation 2. member changes from one network provider to another, which requires a transfer to another contracting facility. Ambulance services dispatched through 911 are only covered if transportation in any other vehicle could endanger your health. Ambulance services will be provided to the nearest facility with the ability to treat your medical condition.
Inpatient Care (Prior authorization by SecureHorizons or your contracting providers is required for inpatient admissions, except for admissions as a result of emergency and out-of-area urgent care.)	
Inpatient Hospital Care (Includes inpatient substance abuse and rehabilitation services.)	Covered services include: ■ Hospital room (private, if medically necessary) ■ Meals, including special diets ■ Regular nursing services ■ Physician services ■ Special care units, such as intensive care or coronary care units ■ Medications while in a hospital ■ Laboratory tests ■ X-rays and other radiology services ■ Necessary surgical and medical supplies ■ Use of appliances, such as wheelchairs ■ Operating room and recovery room ■ Rehabilitation services, such as physical therapy, occupational therapy and speech pathology service ■ All Medicare-approved solid organ transplants (including, but not limited to, kidney, heart, liver, lung and heart/lung, simultaneous pancreas/kidney and pancreas after kidney), when Medicare criteria are met

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Inpatient Care (continued)	■ Medicare-approved intestinal transplants performed at a contracting Medicare-certified transplant center ■ Bone marrow and stem cell transplants, when Medicare criteria are met ■ Blood and its administration You pay a $0 copayment per admission for unlimited days for each Medicare-covered hospital stay. **Original Medicare hospital benefit periods do not apply.** For inpatient hospital care, you are covered for an unlimited number of days, as long as the hospital stay is medically necessary and authorized by SecureHorizons or contracting providers. For professional fees and other transplant-related health services provided in a SecureHorizons United Resource Network Facility, you may pay a copayment.
Inpatient Mental Health Care	You pay a $0 copayment per admission for each Medicare-covered hospital stay. The 190-day lifetime maximum applies in a Medicare-approved, network psychiatric hospital upon referral of a network primary care physician, contracting specialist or contracting mental health care provider in accordance with Medicare guidelines. Benefit is limited by prior partial or complete use of the 190-day lifetime treatment in a free-standing psychiatric hospital or in the psychiatric unit of an acute care hospital that is separate and distinct from the rest of the hospital with a separate staff and administration. Psychiatric care in a general acute care hospital unit does not apply to the 190-day lifetime limit in a free-standing psychiatric hospital or in the psychiatric unit of an acute care hospital that is separate and distinct from the rest of the hospital with a separate staff and administration and is subject to the inpatient hospital benefits.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Skilled Nursing Facility Care (In a Medicare-certified skilled nursing facility.)	■ Skilled nursing facility room (private, if medically necessary) ■ Physician services ■ Meals, including special diets ■ Skilled nursing services ■ Physical therapy, occupational therapy and speech and language pathology services ■ Medications, while in the facility ■ Necessary medical and surgical supplies ■ Use of appliances, such as wheelchairs ■ Laboratory tests ■ X-rays and other radiology services A 3-day prior hospital stay is not required. You pay $0 per admission. You are covered for up to 100 days per benefit period[1] for inpatient services in a skilled nursing facility (SNF), in accordance with Medicare guidelines. Members who reach their 100 days of SNF benefits while in a SNF are entitled to coverage of certain services under Medicare Part B.

[1] A benefit period begins the first day of a Medicare-covered skilled nursing facility (SNF) stay and ends with the close of a period of 60 consecutive days during which you were not a patient of a SNF.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Inpatient Services Inpatient Mental Health Care and Skilled Nursing Facility Care.	**When the inpatient stay itself is not or is no longer covered.** ■ Physician services ■ Diagnostic lab and X-ray services ■ Radiation therapy ■ Prosthetic devices, leg, arm, back and neck braces, as well as trusses ■ Surgical dressings, splints and casts and accessories ■ Physical therapy, occupational therapy and speech and language therapy You pay $0 copayment per admission for an inpatient hospital stay. **Original Medicare hospital benefit periods do not apply.** For inpatient hospital care, you are covered for an unlimited number of days, as long as the hospital stay is medically necessary and authorized by SecureHorizons, or contracting providers. While in a skilled nursing facility, these services and supplies continue to be covered, until a new benefit period[1] begins or until these services and supplies are no longer considered medically necessary or reasonably necessary for the diagnosis and treatment of your illness or injury. For inpatient mental health — No coverage beyond 190 lifetime days in a network or non-network facility, in accordance with Medicare guidelines. Psychiatric care in a general acute hospital is subject to regular hospital benefits.
Other Settings	
Home Health Agency Care	■ Medically necessary part-time or intermittent skilled nursing care and home health aide services, in accordance with Medicare guidelines. This may include any number of days per week, up to 28 hours per week, of skilled nursing or home health aide services combined for less than 8 hours per day, based upon the reasonable need for such care. ■ Medically necessary rehabilitation services (physical therapy, occupational therapy, and speech and language pathology services) ■ Medical social services ■ Medical supplies

[1] A benefit period begins the first day of a Medicare-covered skilled nursing facility (SNF) stay and ends with the close of a period of 60 consecutive days during which you were not a patient of a SNF.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Home Health Agency Care (continued)	■ Physician Services ■ Durable Medical Equipment ■ Outpatient injectable medications ■ Infusion equipment and medications You pay $0 for all home health visits provided by a network home health agency when Medicare criteria are met. Other copayments may apply.
Hospice	Supportive and palliative care for the terminally ill patient at home or in a hospice facility. Hospice care is appropriate when the member has a life expectancy of six months or less, and he or she is not pursuing aggressive treatment. The goal of hospice care is to provide supportive nursing care, pain relief, symptom management and counseling during the terminal phase of the illness. Hospice services in a participating Medicare-certified hospice are not paid for by SecureHorizons, but are reimbursed directly by Medicare when provided by a Medicare-certified hospice. You remain enrolled in MedicareComplete Retiree Plan even though you have elected hospice coverage. SecureHorizons will be responsible to cover certain benefits not covered by Original Medicare. You may use your MedicareComplete Retiree Plan contracting doctor as your hospice-attending physician. SecureHorizons will refer you to a Medicare-participating hospice, if you wish to elect such coverage. You remain enrolled in the plan, although you have elected hospice coverage. SecureHorizons will continue to arrange coverage of non-Medicare-covered benefits, provided as part of your MedicareComplete Retiree Plan benefit plan. As a member, you have the right to get a list of available Medicare-certified hospice providers. (For more information on the Medicare participating hospice program, see the *Medicare & You* handbook.)
Outpatient Medical Services and Supplies	
Outpatient Mental Health Care	You pay a $10 copayment for each Medicare-covered individual/group office visit/therapy session.
Partial Hospitalization Psychiatric Program	You pay a $0 copayment per admission for Medicare-covered benefits.
Outpatient Substance Abuse Services	You pay a $10 copayment for each Medicare-covered individual/group office visit/therapy session.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Outpatient Surgery and Services (Medical/surgical care in a certified ambulatory surgical center or outpatient hospital facility.)	You pay a $0 copayment for each Medicare-covered surgery.
Outpatient Hospital Services (Services, treatments or procedures performed in a hospital outpatient services department setting or a free-standing facility that is not a certified ambulatory surgical center or outpatient surgery department of an acute hospital.)	Examples include, but are not limited to: infusion clinics for drugs or blood products, endoscopies, hyperbaric oxygen and wound care. You pay a $0 copayment per visit for Medicare-covered benefits. You pay the $50 emergency services copayment for covered services received in a hospital emergency department. If you are held for observation (up to 48 hours without being admitted) in an acute hospital or outpatient observation unit after receiving services in a hospital emergency department, you pay the $0 outpatient hospital copayment, instead of the emergency services copayment. You may pay a copayment for covered pain management services, in connection with covered medical and surgical services.
Medicare-covered Outpatient Rehabilitation Services (Comprehensive Outpatient Rehabilitation Facility (CORF), cardiac rehabilitation, pulmonary rehabilitation, occupational therapy, physical therapy and speech and language pathology services.)	You pay a $10 copayment for each Medicare-covered visit.
Durable Medical Equipment (DME) Prosthetics, Orthotics (corrective appliances), Infusion Equipment and Supplies used in conjunction with the above.	You pay $0 for Medicare-covered Durable Medical Equipment, prosthetic devices and medical supplies. The decision to rent or purchase a DME item is determined by your contracting medical group/IPA, primary care physician or SecureHorizons.
Diabetes Self-Management Training	You pay $0 for Medicare-covered self-management training. An office visit copayment will apply. You pay a $10 copayment to see your primary care physician. You pay a $10 copayment to see a specialist.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Diabetes Self-Monitoring Supplies (Includes coverage for glucose monitors, blood glucose test strips, ketone urine test strips, lancets, lancet injector devices and self-management training for insulin and non-insulin dependent diabetics.)	You pay $0 for glucose monitors, blood glucose test strips, ketone urine test strips, lancets and lancet injector devices. Insulin and insulin syringes are covered on the Drug Formulary for a copayment.
Medical Nutrition Therapy (Provided by registered dietitians or other qualified nutrition professionals for people with diabetes and chronic renal disease and for post-transplant patients.)	You pay $0 for Medicare-covered benefits. An office visit copayment will apply. You pay a $10 copayment to see your primary care physician. You pay a $10 copayment to see a specialist..
Imaging Procedures, X-rays and Portable X-rays Used in the Home	You pay $0 for each Medicare-covered standard X-ray visit. You pay $0 for covered complex radiology services and imaging procedures. These procedures require specialized equipment beyond standard X-ray equipment and must be performed by specially trained or certified personnel. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, sonograms, diagnostic mammograms and interventional radiological procedures (myelogram, cystogram, angiogram, and barium studies). An office visit copayment will apply. You pay a $10 copayment to see your primary care physician. You pay a $10 copayment to see a specialist.
Laboratory Services	You pay $0 for Medicare-covered clinical and diagnostic laboratory services.
Radiation Therapy	You pay $0 for each Medicare-covered radiation therapy visit. An office visit copayment may apply. You pay a $10 copayment to see your primary care physician. You pay a $10 copayment to see a specialist.
Medical Supplies (Such as dressings, casts and splints.)	You pay $0 for Medicare-covered benefits. An office visit copayment may apply. You pay a $10 copayment to see your primary care physician. You pay a $10 copayment to see a specialist.
Blood and Its Administration (Coverage begins with the first pint of blood.)	You pay $0 for Medicare-covered benefits. An office visit copayment may apply. You pay a $10 copayment to see your primary care physician. You pay a $10 copayment to see a specialist.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Kidney Dialysis (Services, procedures, treatments and supplies rendered at non-Medicare-certified facilities within the United States will not be covered.)	
■ Routine Hemodialysis and Peritoneal Dialysis	Covered in full at a network facility or at a Medicare-certified facility within the United States.
■ Routine Travel Dialysis	Covered in full at a network facility or at a Medicare-certified facility within the United States.
■ Emergency Dialysis	You pay the $50 emergency room copayment for each Medicare-covered visit; you do not pay this amount if you are admitted to the hospital for the same condition.
Preventive Services	
Bone Mass Measurement (For those at risk, Medicare covers procedures to identify bone mass and detect bone loss, including a physician's interpretation of the results.)	You pay $0 for a Medicare-covered bone mass measurement every 24 months. An office visit copayment will apply. You pay a $10 copayment to see your primary care physician. You pay a $10 copayment to see a specialist.
Colorectal Screening Exams (Colorectal cancer detection for members with Medicare age 50 and older.) ■ Colonoscopy (Screening every 2 years for high risk. For members not at high risk, screening colonoscopy every 10 years or within 4 years of screening flexible sigmoidoscopy.) ■ Screening flexible sigmoidoscopy (Screening every 4 years for members age 50 and older.)	You pay $0 for each Medicare-covered colorectal screening exam. An office visit copayment will apply. You pay a $10 copayment to see your primary care physician. You pay a $10 copayment to see a specialist.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Colorectal Screening Exams (continued) ■ Screening barium enema (As an alternative to either screening sigmoidoscopy or colonoscopy.) (Same screening frequency parameters apply. For members not at high risk of colorectal cancer, screening barium enema every 4 years.) ■ Fecal occult blood testing (Screening every year for members age 50 and older.)	
Annual Screening Mammograms (Screening for women age 40 and older every 12 months. Baseline exam for women ages 35–39.)	You pay $0 for Medicare-covered screening mammogram. No referral necessary for network providers. An office visit copayment will apply. You pay a $10 copayment to see your primary care physician. You pay a $10 copayment to see a specialist.
Direct Access To In-Plan Women's Health Specialists, Including Pap Smears And Pelvic Exams	You may self-refer to an obstetrical/gynecological (OB/GYN) specialist within your MedicareComplete Retiree Plan Service Area or to your primary care physician for a routine Pap smear, pelvic exam and breast exam annually. Exams are covered in full. You pay a $10 copayment per OB/GYN visit. You pay a $10 copayment for a Medicare-covered Pap smear and pelvic exam annually. You pay a $10 copayment for additional Pap smears, if medically necessary. Labs are covered in full. No referral necessary for network providers.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Annual Prostate Cancer Screening Exams (For men with Medicare age 50 and older.) ■ Annual digital rectal exam ■ Annual prostate-specific antigen (PSA) blood test	You pay $0 for a Medicare-covered screening exam. Labs are covered in full. You pay a $10 copayment for each office visit.
Cardiovascular Disease Testing (Blood tests for the detection of cardiovascular disease or abnormalities associated with an elevated risk of cardiovascular disease.)	Cardiovascular disease test offered every 5 years. Cardiovascular screening blood tests are covered for all asymptomatic members for early detection of cardiovascular disease or abnormalities associated with an elevated risk of cardiovascular disease. The screening includes total cholesterol test, cholesterol test for high density lipoproteins and triglycerides test. You pay a $10 copayment for each office visit.
Medicare-covered Physical Exams (For members newly eligible for Medicare Part B benefits only.)	If your coverage for Medicare Part B begins on or after January 1, 2005, you may receive a one-time physical exam within the first six months of your new Part B coverage. The one-time Medicare-covered physical exam will be in lieu of the routine physical exam. Members who receive the one-time Medicare-covered physical exam in a calendar year are not eligible for the routine physical exam until the following calendar year.
Immunizations (Other immunizations may be covered under your Medicare Part D prescription drug benefit.)	
Pneumococcal Pneumonia Vaccine	You pay $0 for the Pneumococcal Pneumonia vaccine. No referral necessary for network providers. An office visit copayment will apply. You pay a $10 copayment to see your primary care physician. You pay a $10 copayment to see a specialist.
Flu Vaccine	You pay $0 for the Influenza vaccine. No referral necessary for network providers. An office visit copayment will apply. You pay a $10 copayment to see your primary care physician. You pay a $10 copayment to see a specialist.
Hepatitis B Vaccine (For members at intermediate or high risk.)	You pay $0 for the Hepatitis B vaccine. An office visit copayment will apply. You pay a $10 copayment to see your primary care physician. You pay a $10 copayment to see a specialist.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
MedicareComplete Part B Prescription Drugs **Medicare Part B Prescription Drugs — Covered under the Medical Benefit (Includes coverage for immunizing agents, biological sera, blood or blood plasma, or drugs (except insulin) prescribed for intravenous or intramuscular use or administration when authorized by your doctor and in accordance with Medicare guidelines.)**	
Medicare Part B Covered Immunosuppressive Drugs (Following a Medicare-approved organ transplant in accordance with Medicare guidelines.)	You pay $0 for covered immunosuppressive drugs.
Medicare Part B Covered Oral Chemotherapy Drugs Including Anti-nausea Drugs	You pay $0 for self-administered Medicare-approved oral chemotherapy drugs, including anti-nausea drugs, for up to a 30-day supply, when prescribed by your doctor as an anti-cancer chemotherapeutic agent.
Medicare Part B Covered Inhalation Solutions	You pay $0 for inhalation solutions, such as Alupent, Isuprel, Metaprel, Proventil, etc. at a network pharmacy. (Hand-held metered dose inhalation units are part of the Medicare Part D Prescription Drug benefit.)
Outpatient Injectable Medications — Self-Administered	You pay $0 for Medicare-covered benefits.
Outpatient Injectable Medications — Administered in a Physician's Office (Medicare-covered drugs that are not self-administered by the patient, and are injected while receiving physician services, including chemotherapy, anti-emetics drugs and infusion medications.)	You pay $0 for Medicare-covered benefits. An office visit copayment will apply.
Hemophilia Clotting Factors	You pay $0 for Medicare-covered benefits.
Antigens (Treatment by RN, injection, including serum.)	You pay $0 for Medicare-covered benefits.
Allergy Testing and Treatment by a Physician	You pay a $10 copayment for Medicare-covered benefits.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Additional Benefits	
Chiropractic Services	
▪ **Medicare-covered (Manual manipulation of the spine to correct subluxation.)**	You pay a $10 copayment for Medicare-covered benefits.
▪ **Routine (non Medicare-covered)**	You pay 100% of the cost for routine chiropractic services.
Dental Services	
▪ **Medicare-covered (Services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of cancer.)**	You pay a $10 copayment for Medicare-covered dental services when referred by your network primary care physician.
▪ **Preventive (non Medicare-covered)**	You pay 100% of the cost for preventive dental services.
▪ **Routine (non Medicare-covered)**	You pay 100% of the cost for routine dental services.
Foot Care	
▪ **Medicare-covered foot care (Includes only those services that meet Medicare criteria for the care of medical conditions affecting the lower limbs, including routine foot care.)**	You pay a $10 copayment for each Medicare-covered visit.
▪ **Routine (non Medicare-covered)**	You pay 100% of the cost for routine foot care services.
Hearing Services	
▪ **Medicare-covered diagnostic hearing exam**	You pay a $10 copayment for each Medicare-covered hearing exam with a network provider.
▪ **Routine Hearing Test and Hearing Aids (non Medicare-covered)**	You pay $10 of the cost for routine hearing tests. You have a $1,000 allowance per calendar year for hearing aids at a network provider.
Temporomandibular Joint Dysfunction (TMJ)	You pay 20%; MedicareComplete pays 80%; lifetime maximum benefit of $1,000 (when Medically Necessary).

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Vision Services	
Eye care – medical need	
▪ **Medicare-covered eye exam**	You pay a $10 copayment for Medicare-covered diagnosis and treatment for diseases and conditions of the eye with a network provider. (Medicare-covered annual glaucoma screening included for members at high risk for glaucoma, members with a family history of glaucoma or members with diabetes.)
▪ **Medicare-covered eyewear**	You pay $0 for one pair of Medicare-covered lenses or contact lenses after each cataract surgery. Allowance for Medicare-covered frames may apply.
Routine Vision Services (non Medicare-covered)	
▪ **Routine eye exam (refraction)**	You pay a $10 copayment for one routine eye exam per year (refractions).
▪ **Routine eyewear or contact lenses**	You pay 100% of the cost for routine eyewear or contact lenses beyond the allowance given. You have a $50 Frames and Lenses OR contact lenses allowance every 12 months. Your medical plan covers one eye exam per year and medically necessary glasses or lenses following cataract surgery. Your Routine Prescription Eyewear benefit provides a routine eye exam, eyeglasses or contact lenses for routine vision correction. If you need the services of an eye specialist, you should call MedicareComplete Customer Service at 1-866-622-8055 (TTY 1-888-685-8480), 8 a.m. to 8 p.m. local time, Monday through Sunday, for the nearest Participating Provider. For a routine eye exam you must go to a network Vision Provider.
Annual Routine Physical Examinations (non Medicare-covered)	You pay a $10 copayment for annual routine physical examinations, limited to one per calendar year.
Optum® NurseLine	You pay $0 for calls to the NurseLine, available 24 hours a day, every day to help you with health and medical questions. Simply call 1-877-365-7949, or for the hearing impaired, call the National Relay Center at 1-800-855-2880 and ask for 1-877-365-7951.

SECTION III: MedicareComplete® Retiree Plan Part D Prescription Drugs — High Option

Your Medicare Advantage Plan includes a Medicare-approved Part D drug benefit.

You automatically receive Medicare Part D prescription drug coverage as part of your benefit plan.

SecureHorizons® Standard Retiree Formulary applies to both retail and mail order prescriptions.

$0–$4,050 Out-of-Pocket Costs

Retail

- You pay a $7 copayment for Tier I preferred generic drugs.
- You pay a $20 copayment for Tier II preferred brand name drugs.
- You pay a $20 copayment for Tier III* non-preferred drugs.
- You pay a $20 copayment for Tier IV specialty drugs per Prescription Unit or up to a 30-day supply.

Mail Service

- You pay a $14 copayment for Tier I preferred generic drugs.
- You pay a $40 copayment for Tier II preferred brand name drugs.
- You pay a $40 copayment for Tier III* non-preferred drugs.
- You pay a $40 copayment for Tier IV specialty drugs up to a 90-day supply through our contracted Mail Service Pharmacy.

*** Exception Policy**

The MedicareComplete Drug Formulary contains many commonly prescribed drugs. During the course of your medical care, there may be instances when your doctor prescribes a drug that is not included on the Formulary, a drug that has Formulary limits or restrictions, or a pharmacist tells you the drug your doctor prescribed is not on the Formulary. Under certain circumstances, we may grant exceptions to Formulary coverage rules. **In order to request a Formulary exception, you must have a statement from your doctor supporting your request.** You may request an exception for the following reasons:

- A drug that is medically necessary to treat your medical condition is not included on the Formulary and a therapeutic substitute is not available.
- The Formulary quantity limits for your prescribed drug are not high enough to treat your medical condition.

All exceptions to the Formulary coverage rules are based on medical necessity.

If you receive a coverage exception for a drug that is not included on the Formulary, you must pay your benefit plan's appropriate copayment or coinsurance.

If we approve your Formulary exception request, the approval is valid for the remainder of the calendar year, as long as your doctor continues to prescribe the drug and as long as the drug continues to be safe and effective in treating your medical condition. If we deny your Formulary exception request, you may appeal our decision.

After Your Yearly Out-of-Pocket Costs Reach: $4,050

You pay the greater of $2.35 for generic or a preferred brand drug that is a multi-source drug, and $5.60 for all other drugs, or 5% coinsurance once your total out-of-pocket costs reach $4,050.

Part D Drug Benefits Questions and Answers

Your MedicareComplete Retiree Plan benefit plan includes a Medicare Part D drug benefit. Because you are enrolled in a MedicareComplete Retiree Plan benefit plan that offers Medicare Part D drug coverage, you may not enroll in any other Medicare Part D drug plan while a member of our plan. If you enroll in any other Medicare Part D drug plan, you will be disenrolled from the MedicareComplete Retiree Plan. Your enrollment in MedicareComplete does not affect your coverage for drugs covered under Medicare Part A and Part B.

What Is the MedicareComplete Drug Formulary?

The MedicareComplete Drug Formulary is a list of Medicare Part D drugs that your contracting providers may use in your medical treatment. It contains many brand name and generic drugs. Most therapeutic classes (for example, antibiotics, anti-depressants, anti-hypertensives) are covered, and many commonly prescribed drugs are included. While we will generally cover the drugs listed on the Formulary, the presence of a drug on the Formulary does not guarantee that your doctor will prescribe that drug to treat your particular medical condition.

Drugs on the Formulary are organized into four different drug tiers, or groups of different drug types. The copayment or coinsurance amounts you pay for a Covered Drug depend on the drug tier for your particular drug.

Under My MedicareComplete Retiree Plan, Can the Drugs I Take Be Removed from the Formulary?

In general, if you are a MedicareComplete Retiree Plan member taking a drug on our Formulary that was covered at the beginning of the calendar year, we will not discontinue or reduce coverage for your drug **during the calendar year. There are two exceptions to this policy:**

- When Generic drugs become available, they may be dispensed in place of Brand Name drugs on the Formulary.
- In the event a drug is determined to be unsafe, we will immediately remove the drug from the Formulary.

Removing a drug from the Formulary will not affect members currently taking the drug. The drug will continue to be available with the same Copayments or Coinsurance for the remainder of the calendar year.

How Can the Formulary Change During the Calendar Year?

The Formulary is updated periodically throughout the year, and the list of drugs may change as drugs are added or deleted from the list. If you do not see your current drugs listed, or if you would like an updated Formulary, please visit our Web site at *www.securehorizons.com* or call Customer Service at 1-866-622-8055 (TTY 1-888-685-8480), 8 a.m. to 8 p.m. local time, Monday through Sunday.

The Formulary may change without notice during the calendar year; however, we will notify you in writing if a Formulary drug you are taking:

- is removed from the Formulary
- has new Prior Authorization requirements
- has reduced quantity limits
- has Step Therapy restrictions

- moves to a higher Copayment or Coinsurance tier

We will notify you at least sixty (60) days prior to a change to a Formulary drug that you are currently taking when the criteria listed above are met. In the event a drug is determined to be unsafe, we will immediately remove the drug from the Formulary.

When Generic drugs become available, they may be dispensed in place of Brand Name drugs on the Formulary.

What Are Covered Drugs?

Covered Drugs are drugs included on the MedicareComplete Drug Formulary and drugs that are not included on the Formulary but have been determined by SecureHorizons to be medically necessary through the exception process.

Where To Have Your Prescriptions Filled

You must use network pharmacies. If you have your prescriptions filled at out-of-network pharmacies, you will most likely have to pay the full cost for your drugs. We contract with many of the largest retail pharmacy chains as well as many local independent pharmacies. You may have your prescriptions filled at any of our network pharmacies nationwide. Also included in our network of contracted pharmacies are long-term care pharmacies, Indian Health Service/Tribal/Urban Indian Health Program (I/T/U) pharmacies and home infusion pharmacies. Only Native Americans and Alaska Natives have access to Indian Health Service/Tribal/Urban Indian Health Program (I/T/U) Pharmacies through MedicareComplete Retiree Plan network pharmacy network. Those other than Native Americans and Alaskan Natives may be able to access these pharmacies under limited circumstances (e.g., emergencies). Sometimes, a particular pharmacy may leave our contracting network. In this situation, have your prescription filled at another network pharmacy, or you will most likely have to pay the full cost of prescriptions filled at a pharmacy that has left our network. Once you have your prescription filled at one network pharmacy, you are not required to continue going to the same network pharmacy to fill your prescriptions. You may go to any of our network pharmacies.

Generally, we will only cover drugs obtained from out-of-network pharmacies under limited circumstances when a network pharmacy is not available. If you are away from home and have an urgent or emergency situation that requires a prescription, and you do not have access to a network pharmacy, you may have your prescription filled at any pharmacy. You may also have your prescriptions filled at an out-of-network pharmacy, in the following situations: 1) if you are unable to get a Covered Drug in a timely manner, because there are no 24-hour network pharmacies within a reasonable driving distance; 2) if your Covered Drug is not carried at a network pharmacy or through mail service (for example, high cost or unique drugs); 3) if you need a prescription while traveling in the United States because you become ill, lose or run out of your prescription drug; 4) if you are getting a vaccine that is medically necessary but not covered by Medicare Part B; 5) if you receive certain Covered Drugs administered in your doctor's office.

If you do go to an out-of-network pharmacy for any of the reasons listed above, you may have to pay the full cost of the Covered Drugs when you fill your prescription (instead of paying the usual copayment or coinsurance). This is because when you fill a prescription at a network pharmacy, the claim is automatically submitted to us by the pharmacy; however, some out-of-network pharmacies may not be able to submit the claim directly to us. You may be responsible for paying the difference between

what we would pay for a prescription filled at a network pharmacy and what the out-of-network pharmacy charged for your prescription. We will reimburse you for the cost of the prescription, minus the applicable copayment or coinsurance. Keep your receipt for proof of purchase and call Customer Service at 1-866-622-8055 (TTY 1-888-685-8480), 8 a.m. to 8 p.m. local time, Monday through Sunday, to request a claim form and to receive instructions on filing a claim. If you receive a bill from an out-of-network pharmacy, **do not pay the bill,** but submit it to us for processing and determination of your liability, if any.

If possible, please call Customer Service at 1-866-622-8055 (TTY 1-888-685-8480), 8 a.m. to 8 p.m. local time, Monday through Sunday, before filling a prescription at an out-of-network pharmacy. The Customer Service representative can advise you if there is a network pharmacy in your area where you can fill your prescription.

For a complete list of network pharmacies in your area, please call Customer Service at 1-866-622-8055 (TTY 1-888-685-8480), 8 a.m. to 8 p.m. local time, Monday through Sunday, and ask for a copy of the Pharmacy Directory or visit our Web site at *www.securehorizons.com*.

How To Fill a Prescription at a network pharmacy

Take your prescription, written by your doctor, to a SecureHorizons network pharmacy.

Present your MedicareComplete Retiree Plan membership card at the network pharmacy.

Once your order is filled, pay your pharmacy copayment or coinsurance for up to a 30-day supply of the prescription drug.

The retail network pharmacy that you choose may allow you to receive a 90-day supply for the applicable copayments (for example, 3 copayments) or coinsurance for your Covered Drug.

Preferred Mail Service Pharmacy

Save money with our convenient mail service pharmacy. The mail service pharmacy offered through Prescription Solutions, our preferred contracting pharmacy provider, provides convenient service and savings on drugs that you take on a regular basis (i.e., maintenance drugs).

Your prescription(s) will be reviewed and filled by a licensed pharmacist and will be mailed to your home to arrive approximately 7 working days from the day Prescription Solutions receives your order. All orders are shipped in discreetly labeled packages, and there are no shipping or handling charges.

Note: Drugs used for short-term or acute illnesses, such as antibiotics, are not available through the mail service pharmacy.

How To Fill a Prescription Through a Mail Service Pharmacy

You may fill a prescription through our preferred mail service pharmacy by calling Prescription Solutions at 1-877-889-6358 (TTY 1-800-498-5428), 24 hours a day, 7 days a week. Please see the Pharmacy Program booklet for details on how to fill a prescription through Prescription Solutions or call Customer Service at 1-866-622-8055 (TTY 1-888-685-8480), 8 a.m. to 8 p.m. local time, Monday through Sunday.

What Is an Explanation of Benefits?

The Explanation of Benefits is a report we mail to you each month when you use your MedicareComplete Retiree Plan Medicare Part D prescription drug benefit. The Explanation of Benefits shows the total amount of copayments and coinsurance you have paid that month on Covered Drugs, together with the total amount we have paid that month for your drugs.

We record your out-of-pocket costs on claims you submit for Covered Drugs until your out-of-pocket costs reach $4,050 in a calendar year. Once your out-of-pocket costs reach $4,050 in a calendar year, you pay significantly reduced copayments and coinsurance amounts for Covered Drugs.

The Explanation of Benefits contains the following information:

- A list of prescriptions you had filled during the previous month, including the amount you paid for each prescription.
- A notification of any unfavorable changes to the Formulary that affects the drugs you are taking, with at least a sixty (60)-day notice.
- A year-to-date summary of your prescription drug costs, including the amounts you and SecureHorizons have paid that count toward the annual initial coverage limit and toward your out-of-pocket costs.
- Information about how to use the exception process and how to appeal our coverage determinations.

If you do not receive an Explanation of Benefits in the mail, please call Customer Service at 1-866-622-8055 (TTY 1-888-685-8480), 8 a.m. to 8 p.m. local time, Monday through Sunday.

Prior Authorization for Selected Drugs on the Formulary

Selected drugs on the Formulary must be prior authorized by us to determine that they are medically necessary and being prescribed according to treatment guidelines consistent with standard professional practice.

Quantity Limits

For certain drugs on the Formulary, we limit the amount of the drug available per prescription. While the standard prescription unit for oral drugs is a 30-day supply, certain drugs have quantity limits that do not use the standard 1-month or 3-month supply. Also, for drugs on the Formulary that could be habit-forming, a quantity limit is set at less than a 30-day supply for your protection and safety. This means you will need to get approval from us before you fill your prescription. If you do not have approval, we may not cover the drug.

Step Therapy Requirements

For selected drugs on the Formulary, we require that you try a certain drug to treat your medical condition before you can be covered for another drug for your condition. For example, we may not cover drug B until you have first tried drug A. If drug A does not work for your medical condition or is inappropriate, we will then cover drug B.

Medication Therapy Management Programs

We provide a Medication Therapy Management (MTM) program at no additional cost for members who have multiple medical conditions, who are taking many covered Medicare Part D prescription drugs and who have high drug costs. This program is required by the Centers for Medicare & Medicaid Services (CMS) for all plans offering Medicare Part D Plan prescription drug coverage and is designed to improve medication use and reduce medication errors. Please be aware this program does not provide financial help such as copayment or coinsurance assistance and does not conduct clinical studies.

The MTM program is provided to members who meet specific criteria. We will determine if you meet the criteria. If you qualify, we will notify you.

Through this program, we will provide you with information about medications that are used in certain conditions. Also, we will identify possible medication errors as well as ways to better manage certain conditions through appropriate medication use.

Drug Utilization Review

We conduct drug utilization reviews for all of our members to make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribe their medications. We conduct drug utilization reviews on a regular basis by reviewing our records. During these reviews, we look for medication problems such as: possible medication errors; duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition; drugs that are inappropriate because of your age or gender; possible harmful interactions between drugs you are taking; drug allergies; drug dosage errors.

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Exception Policy

The MedicareComplete Drug Formulary contains many commonly prescribed drugs. During the course of your medical care, there may be instances when your doctor prescribes a drug that is not included on the Formulary, a drug that has Formulary limits or restrictions, or a pharmacist tells you the drug your doctor prescribed is not on the Formulary. Under certain circumstances, we may grant exceptions to Formulary coverage rules. **In order to request a Formulary exception, you must have a statement from your doctor supporting your request.** You may request an exception for the following reasons:

- A drug that is medically necessary to treat your medical condition is not included on the Formulary and a therapeutic substitute is not available.
- The Formulary quantity limits for your prescribed drug are not high enough to treat your medical condition.

All exceptions to the Formulary coverage rules are based on medical necessity.

If you receive a coverage exception for a drug that is not included on the Formulary, you must pay your benefit plan's appropriate copayment or coinsurance.

If we approve your Formulary exception request, the approval is valid for the remainder of the calendar year, as long as your doctor continues to prescribe the drug and as long as the drug continues to be safe and effective in treating your medical condition. If we deny your Formulary exception request, you may appeal our decision.

What if My Drug Is Not on the Formulary?

If your drug is not included on the Formulary, please call Customer Service at 1-866-622-8055 (TTY 1-888-685-8480), 8 a.m. to 8 p.m. local time, Monday through Sunday, and ask if your drug is covered. If we do not cover your drug, you have two options:

- Ask Customer Service for a list of similar drugs that are on the Formulary. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is on the Formulary.
- You can ask us to make an exception and cover your drug.

As a new MedicareComplete Retiree Plan member, you may be taking drugs that are not included on our Formulary. You may also be taking a drug that is on our Formulary, but the drug has prior authorization requirements or quantity limits. In these cases, you should discuss your options with your doctor. Your doctor may recommend that you switch to a different drug or ask us for a Formulary exception. In certain cases, we will cover your current drug during your first 90 days as a MedicareComplete Retiree Plan member.

For each of your current drugs that are not on our Formulary or have Formulary restrictions, we will cover a temporary 30-day transitional supply of the drug (unless your prescription is for fewer days) at network Pharmacies. After the first 30-day supply, we will not pay for these drugs, even if you have been a member for less than 90 days.

Important note to residents of long-term care facilities: We will cover a temporary, 31-day transitional supply (unless your prescription is for fewer days). We will cover more than one refill of these drugs for your first 90 days as a MedicareComplete Retiree Plan member. If you need a drug that is not on our Formulary or that has Formulary restrictions, but you have been a MedicareComplete Retiree Plan member for more than 90 days, we will cover a 31-day emergency supply of that drug (unless you have a prescription written for fewer days), while you pursue a Formulary exception.

What Is a Coverage Determination?

A Coverage Determination is a decision made by us regarding coverage for Medicare Part D prescription drugs. Coverage Determinations include requests for exceptions, as described above, and requests for coverage in the following situations:

- When you have been denied a Medicare Part D prescription drug that you believe should be covered by us.

- When payment has been denied for a Medicare Part D prescription drug you have received and you believe should be covered.
- When the coverage for your Medicare Part D prescription drug has been reduced or removed from the Formulary.
- When you have filled a prescription at an out-of-network pharmacy and you want reimbursement.

You, your doctor or someone you name may request a Coverage Determination. The person you name would be your appointed representative. You may name a relative, a friend, advocate, doctor or someone else to act for you. Please see the Evidence of Coverage for more information on how to name an appointed representative.

You also have the right to have an attorney ask for a Coverage Determination on your behalf. You may contact your own attorney, or get the name of an attorney from a referral service.

Coverage Determination Timeframes:

- **Standard Coverage Determinations must be completed within seventy-two (72) hours**
- **Expedited Coverage Determinations must be completed within twenty-four (24) hours**

Standard Coverage Determination

Standard Coverage Determination requests are appropriate in situations such as reimbursement for Medicare Part D prescription drugs that you have already received. In this situation, you generally will be notified of the decision within seventy-two (72) hours of your request.

Standard Coverage Determination requests for Formulary exceptions, drug tier exceptions or exceptions from drug quantity limits or step therapy requirements must be medically necessary and supported with a physician's statement. In these situations, we must make a Coverage Determination within seventy-two (72) hours after receiving your physician's supporting statement and must notify you of the decision. If we do not approve your request (an adverse Coverage Determination), the written notice will state the reasons for the denial and inform you of your right to file an Appeal.

If you do not receive a Coverage Determination notification within seventy-two (72) hours of your request, we must submit the request to an Independent Review Entity (IRE) for review within twenty-four (24) hours of the expiration of the required timeframe.

If your request for a standard Coverage Determination regarding an exception is decided in your favor, we will notify you and authorize the drug you requested within seventy-two (72) hours after receiving your physician's supporting statement. If your request for a standard Coverage Determination regarding a reimbursement for a drug that you have already received is decided in your favor, we must notify you and send you payment no later than thirty (30) days after the receipt of your request.

Expedited 24-Hour Coverage Determination

You may request and receive an expedited twenty-four (24)-hour Coverage Determination in situations in which waiting for a decision within the standard timeframe could seriously jeopardize your life, health, or your ability to function. If we decide, based on medical criteria, that your situation requires an expedited Coverage Determination, or if any doctor calls or writes in support of your request for an expedited Coverage Determination, we will issue a decision as expeditiously as possible, but no later than twenty-four (24) hours after receiving the request.

If you request an expedited twenty-four (24)-hour Coverage Determination without support from a physician, we will determine if your health situation requires the expedited twenty-four (24)-hour Coverage Determination. If we determine that your health situation does not require an expedited twenty-four (24)-hour Coverage Determination, you will be notified. The written notification may explain that your expedited Coverage Determination request lacked necessary physician support. The notification will explain that you have the right to file a Grievance based on our denial of your request for an expedited review and that your request will be reviewed within the standard seventy-two (72)-hour timeframe.

If we determine that your request for an expedited Coverage Determination is appropriate, but you do not receive a decision from us within twenty-four (24)-hours of your request, your request will automatically be elevated to the second level of an Appeal and will be reviewed by an Independent Review Entity (IRE).

If your expedited twenty-four (24)-hour Coverage Determination involving an exception request is decided in your favor, we must notify you and authorize or provide the drug you requested within twenty-four (24) hours after receiving your physician's supporting statement.

How To Request a Standard Coverage Determination

To request a Standard Coverage Determination, you or your authorized representative may call, write, or fax us.

Call: 1-866-622-8055
8 a.m. to 8 p.m. local time
Monday through Sunday
We will document your request in writing.

TTY: 1-888-685-8480
8 a.m. to 8 p.m. local time
Monday through Sunday
We will document your request in writing.

Write: Customer Service
Coverage Determinations
P.O. Box 6006
Cypress, CA 90630
Mailstop: CA124-0157

Fax: Coverage Determinations
1-800-346-0930

Note: The Customer Service representative will record the date and time of all telephone or fax requests for Coverage Determinations received on Saturday or Sunday or before or after business hours Monday through Friday. For standard Coverage Determination requests, the seventy-two (72)-hour period will begin at the time the request is received.

How To Request an Expedited Coverage Determination

To request an expedited Coverage Determination, you or your authorized representative may call, fax or visit us. **Please indicate that you want an expedited twenty-four (24)-hour Coverage Determination when you speak to the Customer Service representative or send the fax.**

During normal business hours, call or fax:

Call: 1-866-622-8055
8 a.m. to 8 p.m. local time
Monday through Sunday
We will document your request in writing.

TTY: 1-888-685-8480
8 a.m. to 8 p.m. local time
Monday through Sunday
We will document your request in writing.

Fax: Coverage Determinations
1-800-346-0930

SECTION IV: Your MedicareComplete® Retiree Plan Benefits — Low Option (through a network medical provider)

Summary of MedicareComplete Retiree Plan Low-Option Benefits

Effective Date: 1/1/2008 to 12/31/2008

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Physician Services	
■ Primary Care Physician	$10 copayment per office visit
■ Specialist	$20 copayment per office visit
Emergency Department Services	
■ Within and Outside of the United States	$50 copayment; waived if admitted to the hospital
Urgently Needed Care	
■ Primary Care Physician	$35 copayment per visit
■ In-area/in-network provider other than primary care physician	$35 copayment per visit
■ In-area/non-network provider or out-of-area provider	$35 copayment per visit
Ambulance Services	$100 copayment per Medicare-covered trip
Inpatient Care	
Inpatient Hospital Care	$500 copayment per admission for unlimited days as medically necessary
Transplants	$1,500 copayment per transplant
Inpatient Mental Health Care	$500 copayment per admission; 190-day lifetime maximum
Skilled Nursing Facility Care	Days 1–20: Covered in Full Days 21–100: $75 copayment per day; maximum of 100 days per benefit period
Other Settings	
Home Health Agency Care	covered in full
Hospice	Reimbursed directly by Medicare; Refer to *Medicare & You* handbook
Outpatient Medical Services and Supplies	
Outpatient Mental Health Care	$10 copayment per Group visit $20 copayment per Individual visit

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Partial Hospitalization Psychiatric Program	$60 copayment per day
Outpatient Substance Abuse Services	$10 copayment per Group visit $20 copayment per Individual visit
Outpatient Surgery, Observation and Services	$125 copayment per visit
Outpatient Hospital Services	$25 copayment per visit
Medicare-covered Outpatient Rehabilitation Services	$25 copayment per office visit
Durable Medical Equipment (DME)	You pay 20% coinsurance
Diabetes Self-Management Training	covered in full
Diabetes Self-Monitoring Supplies	covered in full
Medical Nutrition Therapy	covered in full
Imaging Procedures, X-rays and Portable X-rays Used in the Home	
▪ Medicare-covered Standard X-rays	$10 copayment per visit
▪ Complex Radiology Services and Imaging Procedures	$10 copayment per visit
Laboratory Services	$10 copayment per visit
Radiation Therapy	You pay 20% coinsurance
Medical Supplies	covered in full
Blood and Its Administration	covered in full
Kidney Dialysis	You pay 20% coinsurance at a network facility or at a Medicare-certified facility within the United States
Preventive Services	
Bone Mass Measurement	covered in full
Colorectal Screening Exams	$20 copayment per visit
Annual Screening Mammograms	$10 copayment per visit
Well-Woman Care/Pap Smears and Pelvic Exams	$10 copayment per visit.
Annual Prostate Cancer Screening Exams	$10 copayment per visit

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Cardiovascular Disease Testing	$20 copayment per visit
Immunizations	
Immunizations	
■ Pneumococcal Pneumonia Vaccine	covered in full
■ Flu Vaccine	covered in full
■ Hepatitis B Vaccine	covered in full
Part B Prescription Drugs	
Medicare Part B covered Prescription Drugs	
■ Immunosuppressive Drugs	You pay 20% coinsurance
■ Chemotherapy Drugs including Anti-nausea Drugs	You pay 20% coinsurance
■ Inhalation Solutions	You pay 20% coinsurance
Outpatient Injectable Medications	
■ Self-Administered	You pay 20% coinsurance
■ Administered in a Physician's Office	You pay 20% coinsurance
■ Home Health	You pay 20% coinsurance
Hemophilia Clotting Factors	
■ Self-Administered	You pay 20% coinsurance
■ Administered in a Physician's Office	You pay 20% coinsurance
■ Home Health	You pay 20% coinsurance
Antigens	You pay 20% coinsurance
Allergy Testing	$20 copayment per visit
Additional Benefits	
Chiropractic Services	
■ Medicare-covered	$20 copayment per office visit
■ Routine	Not Covered
Dental Services	
■ Medically Necessary Services	$20 copayment per office visit
■ Routine	Not Covered

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Foot Care	
■ Medicare-covered	$20 copayment per office visit
■ Routine	Not Covered
Hearing Services	
■ Medicare-covered Diagnostic Hearing Examination	$20 copayment per visit
■ Routine Hearing Examination for Hearing Aids	$20 copayment per visit
■ Hearing Aids	$1,000 allowance per calendar year
Vision Care Services	
■ Medicare-covered Eye Exam	$20 copayment
■ Medicare-covered Eyewear or Contact Lenses	covered in full
Routine Eye Exam and Eyewear or Contact Lenses	
■ Routine Eye Exam	$20 copayment; one exam per year
■ Routine Eyewear or Contact Lenses	$50 Frames and Lenses OR contact lenses allowance every 12 months
Annual Routine Physical Examinations (non Medicare-covered)	Medicare initial preventive physical exam covered in full; $10 copayment for annual routine physical examination
Optum® NurseLine	You pay $0 for calls to the NurseLine, available 24 hours a day, every day, to help you with health and medical questions. Simply call 1-877-365-7949, or for the hearing impaired, call the National Relay Center at 1-800-855-2880 and ask for 1-877-365-7951.
Out-of-Pocket Maximum Maximum includes medical copayments and coinsurance only. Prescription drugs, vision hardware, and hearing aids do not apply towards maximum.	$2,400 per person per calendar year
Part D — Outpatient Prescription Drugs	
$0 – $4,050 Out-of-Pocket Costs	
Retail	You pay a $20 copayment for Tier I preferred generic drugs. You pay a $40 copayment for Tier II preferred brand name drugs. You pay a $40 copayment for Tier III non-preferred drugs. You pay a $40 copayment for Tier IV specialty drugs per Prescription Unit or up to a 30-day supply.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Mail Service	You pay a $40 copayment for Tier I preferred generic drugs. You pay an $80 copayment for Tier II preferred brand name drugs. You pay an $80 copayment for Tier III non-preferred drugs. You pay an $80 copayment for Tier IV specialty drugs per up to a 90-day supply through our contracted Mail Service Pharmacy
After Your Yearly Out-of-Pocket Costs Reach: $4,050	You pay the greater of $2.35 for generic or a preferred brand drug that is a multi-source drug, and $5.60 for all other drugs, or 5% coinsurance once your total out-of-pocket costs reach $4,050.
Your MedicareComplete Retiree Plan Benefits	
Health Plan Premium	In most cases, your plan sponsor is responsible for making payment of any applicable Health Plan Premium directly to SecureHorizons® on behalf of its enrolled MedicareComplete Retiree Plan Members and their eligible dependent(s). Your Plan Sponsor determines the amount of any retiree subscriber contribution toward Health Plan Premiums. Some Plan Sponsors, however, have made arrangements with SecureHorizons to bill you, the Member, directly for Health Plan Premiums. If this is the case, your monthly Health Plan Premium is due on the first day of each month for the prior month's coverage. Refer to the ADOA Enrollment Guide for your Monthly Health Plan Premium amount.
Doctor and Hospital Choice	You must go to network doctors, specialists and hospitals. You need a referral to go to network specialists. You need prior authorization to go to non-network doctors, specialists or hospitals.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Physician Services	
■ Consultation, diagnosis and treatment by a network primary care physician, or under certain circumstances, treatment by a nurse practitioner or physician's assistant. You pay the same copayment for a Coumadin clinic visit under a physician's supervision.	You pay a $10 copayment for each office visit.
■ Second opinion by another network medical provider for a recommended procedure and/or service.	You pay a $10 copayment for each second opinion with a primary care physician.
■ Consultation, diagnosis and treatment by a specialist for a recommended procedure and/or service.	You pay a $20 copayment for each visit with a specialist.
■ Inpatient physician services, including medical, surgical, psychiatric and skilled nursing care.	You pay a $500 hospitalization copayment.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Emergency Department Services (You may go to any hospital-based emergency department for emergency care.)	Emergency services covered include inpatient or outpatient services that are: 1) furnished by a provider qualified to furnish emergency services, and 2) needed to evaluate or stabilize an emergency medical condition. An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1. placing your health in serious jeopardy; serious impairment to bodily functions; 2. serious dysfunction of any bodily organ or part. 3. In the case of a pregnant woman, an Emergency Medical Condition exists if the member is in Active Labor, meaning labor at a time in which either of the following would occur: a) there is inadequate time to effect safe transfer to another hospital prior to delivery; or b) a transfer may pose a threat to the health and safety of the member or the unborn child. You pay $50 for each Medicare-covered emergency room visit (within and outside of the United States); this amount is waived if you are admitted to the hospital for the same condition. You pay a $500 hospitalization copayment. Post-stabilization services are included. Post-stabilization services are medically necessary, non-emergency services to ensure that you remain stabilized from the time a non-network medical provider or facility requests authorization from us until: 1. you are discharged 2. a network medical provider arrives and assumes responsibility for your care 3. the non-network medical provider and we agree to other arrangements 4. a contracting provider assumes responsibility for your care through the transfer to a contracting facility. Members should notify their network primary care physician or us within 48 hours, or as soon as possible after receiving emergency and urgently needed services.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Urgently Needed Care	Urgently needed covered services include services provided when: a) you are temporarily absent from the area serviced by your network provider, and the services cannot be delayed until you return to the Service Area, or b) you are within the Service Area but your network provider or other contracted provider is unavailable or inaccessible, and the services cannot be delayed until you return to the Service Area. You pay a $35 copayment for each Medicare-covered visit with your primary care physician during regular office hours. You pay a $35 copayment for each Medicare-covered visit with an in-area/in-network provider, other than your primary care physician before or after regular office hours. You pay a $35 copayment for each Medicare-covered visit with an in-area/non-network provider or from an out-of-area provider. Services received from an in-area/non-network provider are covered only under unusual and extraordinary circumstances, such as covered services provided when you are in your Service Area, but your network is temporarily unavailable or inaccessible, and when such services are medically necessary and immediately required: 1) as a result of unforeseen illness, injury or condition, and 2) it is not possible, given the circumstances, to receive services through your network provider. You pay these amounts even if you are admitted to the hospital for the same condition. Includes dialysis for acute kidney failure. Post-stabilization services are included. Post-stabilization services are medically necessary, non-emergency services to ensure that you remain stabilized from the time a non-network medical provider or facility requests authorization from us until: 1. you are discharged 2. a network medical provider arrives and assumes responsibility for your care 3. the non-network medical provider and we agree to other arrangements 4. a contracting provider assumes responsibility for your care through the transfer to a contracting facility. Worldwide coverage.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Ambulance Services (Air, water or ground transportation.) Medical necessity limitations apply.	You pay a $100 copayment per Medicare-covered ambulance trip. Member-initiated ambulance transportation for reasons not primarily medical in nature, and which serve only as a convenience to the member and/or the member's family, are not covered. Examples include, but are not limited to: 1. geographic relocation 2. member changes from one network provider to another, which requires a transfer to another contracting facility. Ambulance services dispatched through 911 are only covered if transportation in any other vehicle could endanger your health. Ambulance services will be provided to the nearest facility with the ability to treat your medical condition.
Inpatient Care **(Prior authorization by SecureHorizons or your contracting providers is required for inpatient admissions, except for admissions as a result of emergency and out-of-area urgent care.)**	
Inpatient Care (Includes inpatient substance abuse and rehabilitation services.)	Covered services include: ■ Hospital room (private, if medically necessary) ■ Meals, including special diets ■ Regular nursing services ■ Physician services ■ Special care units, such as intensive care or coronary care units ■ Medications while in a hospital ■ Laboratory tests ■ X-rays and other radiology services ■ Necessary surgical and medical supplies ■ Use of appliances, such as wheelchairs ■ Operating room and recovery room ■ Rehabilitation services, such as physical therapy, occupational therapy and speech pathology service ■ All Medicare-approved solid organ transplants (including, but not limited to, kidney, heart, liver, lung and heart/lung, simultaneous pancreas/kidney and pancreas after kidney), when Medicare criteria are met.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Inpatient Care (continued)	■ Medicare-approved intestinal transplants performed at a contracting Medicare-certified transplant center ■ Bone marrow and stem cell transplants, when Medicare criteria are met ■ Blood and its administration You pay a $500 copayment per admission for unlimited days for each Medicare-covered hospital stay. You pay a $1,500 copayment per transplant for each Medicare-covered transplant. Inpatient Hospital Copayments are charged on a per admission basis. **Original Medicare hospital benefit periods do not apply.** For inpatient hospital care, you are covered for an unlimited number of days, as long as the hospital stay is medically necessary and authorized by SecureHorizons or contracting providers. When you are admitted to an inpatient hospital and then are later transferred to another inpatient hospital, you pay the copayment charged for the first hospital admission. You do not pay a copayment for the second hospital admission. Once you are discharged from a hospital, any other hospital admissions, even for the same medical condition at the same hospital, will require a hospital copayment. In certain circumstances, you may be discharged from a hospital and transferred to a skilled nursing care unit or transitional care unit within the same hospital. If you are later re-admitted to the hospital from the skilled nursing care unit or transitional care unit, you will pay the hospital copayment. For professional fees and other transplant-related health services provided in a SecureHorizons United Resource Network Facility, you may pay a copayment.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Inpatient Mental Health Care	You pay a $500 copayment per admission for each Medicare-covered hospital stay. Inpatient mental health care copayments are charged on a per admission basis. The 190-day lifetime maximum applies in a Medicare-approved, network psychiatric hospital upon referral of a network primary care physician, contracting specialist or contracting mental health care provider in accordance with Medicare guidelines. Benefit is limited by prior partial or complete use of the 190-day lifetime treatment in a free-standing psychiatric hospital or in the psychiatric unit of an acute care hospital that is separate and distinct from the rest of the hospital with a separate staff and administration. Psychiatric care in a general acute care hospital unit does not apply to the 190-day lifetime limit in a free-standing psychiatric hospital or in the psychiatric unit of an acute care hospital that is separate and distinct from the rest of the hospital with a separate staff and administration and is subject to the inpatient hospital benefits.
Skilled Nursing Facility Care (In a Medicare-certified skilled nursing facility.)	■ Skilled nursing facility room (private, if medically necessary) ■ Physician services ■ Meals, including special diets ■ Skilled nursing services ■ Physical therapy, occupational therapy and speech and language pathology services ■ Medications, while in the facility ■ Necessary medical and surgical supplies ■ Use of appliances, such as wheelchairs ■ Laboratory tests ■ X-rays and other radiology services A 3-day prior hospital stay is not required. Days 1–20: You pay $0 per admission. Days 21–100: You pay a $75 copayment per day. You are covered for up to 100 days per benefit period[1] for inpatient services in a skilled nursing facility (SNF), in accordance with Medicare guidelines. Members who reach their 100 days of SNF benefits while in a SNF are entitled to coverage of certain services under Medicare Part B.

[1] A benefit period begins the first day of a Medicare-covered skilled nursing facility (SNF) stay and ends with the close of a period of 60 consecutive days during which you were not a patient of a SNF.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Inpatient Services Inpatient Mental Health Care and Skilled Nursing Facility Care.	**When the inpatient stay itself is not or is no longer covered.** ■ Physician services ■ Diagnostic lab and X-ray services ■ Radiation therapy ■ Prosthetic devices, leg, arm, back and neck braces, as well as trusses ■ Surgical dressings, splints and casts and accessories ■ Physical therapy, occupational therapy and speech and language therapy You pay an inpatient hospital care $500 copayment per admission. **Original Medicare hospital benefit periods do not apply.** For inpatient hospital care, you are covered for an unlimited number of days, as long as the hospital stay is medically necessary and authorized by SecureHorizons, or contracting providers. While in a skilled nursing facility, these services and supplies continue to be covered, until a new benefit period[1] begins or until these services and supplies are no longer considered medically necessary or reasonably necessary for the diagnosis and treatment of your illness or injury. For inpatient mental health — No coverage beyond 190 lifetime days in a network or non-network facility, in accordance with Medicare guidelines. Psychiatric care in a general acute hospital is subject to regular hospital benefits.
Other Settings	
Home Health Agency Care	■ Medically necessary part-time or intermittent skilled nursing care and home health aide services, in accordance with Medicare guidelines. This may include any number of days per week, up to 28 hours per week, of skilled nursing or home health aide services combined for less than 8 hours per day, based upon the reasonable need for such care. ■ Medically necessary rehabilitation services (physical therapy, occupational therapy, and speech and language pathology services)

[1] A benefit period begins the first day of a Medicare-covered skilled nursing facility (SNF) stay and ends with the close of a period of 60 consecutive days during which you were not a patient of a SNF.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Home Health Agency Care (continued)	■ Medical social services ■ Medical supplies ■ Physician Services ■ Durable Medical Equipment ■ Outpatient Injectable medications ■ Infusion equipment and medications You pay $0 for all home health visits provided by a network home health agency when Medicare criteria are met. Other copayments may apply.
Hospice	Supportive and palliative care for the terminally ill patient at home or in a hospice facility. Hospice care is appropriate when the member has a life expectancy of six months or less, and he or she is not pursuing aggressive treatment. The goal of hospice care is to provide supportive nursing care, pain relief, symptom management and counseling during the terminal phase of the illness. Hospice services in a participating Medicare-certified hospice are not paid for by SecureHorizons, but are reimbursed directly by Medicare when provided by a Medicare-certified hospice. You remain enrolled in MedicareComplete Retiree Plan even though you have elected hospice coverage. SecureHorizons will be responsible to cover certain benefits not covered by Original Medicare. You may use your MedicareComplete Retiree Plan contracting doctor as your hospice-attending physician. SecureHorizons will refer you to a Medicare-participating hospice, if you wish to elect such coverage. You remain enrolled in the plan, although you have elected hospice coverage. SecureHorizons will continue to arrange coverage of non-Medicare-covered benefits, provided as part of your MedicareComplete Retiree Plan benefit plan. As a member, you have the right to get a list of available Medicare certified hospice providers. (For more information on the Medicare participating hospice program, see the *Medicare & You* handbook.)
Outpatient Medical Services and Supplies	
Outpatient Mental Health Care	You pay a $10 copayment for each Medicare-covered Group office visit/therapy session. You pay a $20 copayment for each Medicare-covered Individual office visit/therapy session.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Partial Hospitalization Psychiatric Program	You pay a $60 copayment per day for Medicare-covered benefits.
Outpatient Substance Abuse Services	You pay a $10 copayment for each Medicare-covered Group office visit/therapy session. You pay a $20 copayment for each Medicare-covered Individual office visit/therapy session.
Outpatient Surgery, Observation and Services (Medical/surgical care in a certified ambulatory surgical center or outpatient hospital facility.)	You pay a $125 copayment for each Medicare-covered visit.
Outpatient Hospital Services (Services, treatments or procedures performed in a hospital outpatient services department setting or a free-standing facility that is not a certified ambulatory surgical center or outpatient surgery department of an acute hospital.)	Examples include, but are not limited to: infusion clinics for drugs or blood products, endoscopies, hyperbaric oxygen and wound care. You pay a $25 copayment per visit for Medicare-covered benefits. You pay the $50 emergency services copayment for covered services received in a hospital emergency department. If you are held for observation (up to 48 hours without being admitted) in an acute hospital or outpatient observation unit after receiving services in a hospital emergency department, you pay the $125 outpatient hospital observation copayment, instead of the emergency services copayment. You may pay a copayment for covered pain management services, in connection with covered medical and surgical services.
Medicare-covered Outpatient Rehabilitation Services (Comprehensive Outpatient Rehabilitation Facility (CORF), cardiac rehabilitation, pulmonary rehabilitation, occupational therapy, physical therapy and speech and language pathology services.)	You pay $25 for each Medicare-covered visit.
Durable Medical Equipment (DME) Prosthetics, Orthotics (corrective appliances), Infusion Equipment and Supplies used in conjunction with the above.	You pay 20% coinsurance for Medicare-covered Durable Medical Equipment, prosthetic devices and medical supplies. The decision to rent or purchase a DME item is determined by your contracting medical group/IPA, primary care physician or SecureHorizons.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Diabetes Self-Management Training	You pay $0 for Medicare-covered self-management training. An office visit copayment will apply. You pay a $10 copayment to see your primary care physician. You pay a $20 copayment to see a specialist.
Diabetes Self-Monitoring Supplies (Includes coverage for glucose monitors, blood glucose test strips, ketone urine test strips, lancets, lancet injector devices and self-management training for insulin and non-insulin dependent diabetics.)	You pay $0 for glucose monitors, blood glucose test strips, ketone urine test strips, lancets and lancet injector devices. Insulin and insulin syringes are covered on the Drug Formulary for a copayment.
Medical Nutrition Therapy (Provided by registered dietitians or other qualified nutrition professionals for people with diabetes and chronic renal disease and for post-transplant patients.)	You pay $0 for Medicare-covered benefits. An office visit copayment will apply. You pay a $10 copayment to see your primary care physician. You pay a $20 copayment to see a specialist.
Imaging Procedures, X-rays and Portable X-rays Used in the Home	You pay $10 for each Medicare-covered standard X-ray visit. You pay a $10 copayment for covered complex radiology services and imaging procedures. These procedures require specialized equipment beyond standard X-ray equipment and must be performed by specially trained or certified personnel. Examples include, but are not limited to, specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, sonograms, diagnostic mammograms and interventional radiological procedures (myelogram, cystogram, angiogram, and barium studies). An office visit copayment will apply. You pay a $10 copayment to see your primary care physician. You pay a $20 copayment to see a specialist.
Laboratory Services	You pay $10 for Medicare-covered clinical and diagnostic laboratory services.
Radiation Therapy	You pay 20% coinsurance for each Medicare-covered radiation therapy visit. An office visit copayment may apply. You pay a $10 copayment to see your primary care physician. You pay a $20 copayment to see a specialist.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Medical Supplies (Such as dressings, casts and splints.)	You pay $0 for Medicare-covered benefits. An office visit copayment may apply. You pay a $10 copayment to see your primary care physician. You pay a $20 copayment to see a specialist.
Blood and Its Administration (Coverage begins with the first pint of blood.)	You pay $0 for Medicare-covered benefits. An office visit copayment may apply. You pay a $10 copayment to see your primary care physician. You pay a $20 copayment to see a specialist.
Kidney Dialysis (Services, procedures, treatments and supplies rendered at non-Medicare-certified facilities within the United States will not be covered.)	
■ Routine Hemodialysis and Peritoneal Dialysis	Covered in full at a network facility or at a Medicare-certified facility within the United States.
■ Routine Travel Dialysis	You pay 20% coinsurance at a network facility or at a Medicare-certified facility within the United States.
■ Emergency Dialysis	You pay the $50 emergency room copayment for each Medicare-covered visit; you do not pay this amount if you are admitted to the hospital for the same condition. The $500 hospital per admission copayment will apply.
Preventive Services	
Bone Mass Measurement (For those at risk, Medicare covers procedures to identify bone mass and detect bone loss, including a physician's interpretation of the results.)	You pay $0 for a Medicare-covered bone mass measurement every 24 months. An office visit copayment will apply. You pay a $10 copayment to see your primary care physician. You pay a $20 copayment to see a specialist.
Colorectal Screening Exams (Colorectal cancer detection for members with Medicare age 50 and older.) ■ Colonoscopy (Screening every 2 years for high risk. For members not at high risk, screening colonoscopy every 10 years or within 4 years of screening flexible sigmoidoscopy.) ■ Screening flexible sigmoidoscopy (Screening every 4 years for members age 50 and older.)	You pay $0 for each Medicare-covered colorectal screening exam. An office visit copayment will apply. You pay a $10 copayment to see your primary care physician. You pay a $20 copayment to see a specialist.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Colorectal Screening Exams (continued) ■ Screening barium enema (As an alternative to either screening sigmoidoscopy or colonoscopy.) (Same screening frequency parameters apply. For members not at high risk of colorectal cancer, screening barium enema every 4 years.) ■ Fecal occult blood testing (Screening every year for members age 50 and older.)	
Annual Screening Mammograms (Screening for women age 40 and older every 12 months. Baseline exam for women ages 35–39.)	You pay a $10 copayment for Medicare-covered screening mammogram. No referral necessary for network providers. An office visit copayment will apply. You pay a $10 copayment to see your primary care physician. You pay a $20 copayment to see a specialist.
Direct Access To In-Plan Women's Health Specialists Including Pap Smears And Pelvic Exams	You may self-refer to an obstetrical/gynecological (OB/GYN) specialist within your MedicareComplete Service Area or to your primary care physician for a routine Pap smear, pelvic exam and breast exam annually. Exams are covered in full. You pay a $10 copayment per OB/GYN visit. You pay a $10 copayment for a Medicare-covered Pap smear and pelvic exam annually. You pay a $10 copayment for additional Pap smears, if medically necessary. Labs are a $10 copayment per visit. No referral necessary for network providers.
Annual Prostate Cancer Screening Exams (For men with Medicare age 50 and older.) ■ Annual digital rectal exam ■ Annual prostate-specific antigen (PSA) blood test	You pay $0 for Medicare-covered screening exam. Labs are a $10 copayment per visit. You pay a $10 copayment for each office visit.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Cardiovascular Disease Testing (Blood tests for the detection of cardiovascular disease or abnormalities associated with an elevated risk of cardiovascular disease.)	Cardiovascular disease test offered every 5 years. Cardiovascular screening blood tests are covered for all asymptomatic members for early detection of cardiovascular disease or abnormalities associated with an elevated risk of cardiovascular disease. The screening includes total cholesterol test, cholesterol test for high density lipoproteins and triglycerides test. You pay a $20 copayment for each office visit.
Medicare-covered Physical Exams (For members newly eligible for Medicare Part B benefits only.)	If your coverage for Medicare Part B begins on or after January 1, 2005, you may receive a one-time physical exam within the first six months of your new Part B coverage. The one-time Medicare-covered physical exam will be in lieu of the routine physical exam. Members who receive the one-time Medicare-covered physical exam in a calendar year are not eligible for the routine physical exam until the following calendar year.
Immunizations (Other immunizations may be covered under your Medicare Part D prescription drug benefit.)	
Pneumococcal Pneumonia Vaccine	You pay $0 for the Pneumococcal Pneumonia vaccine. No referral necessary for network providers. An office visit copayment will apply. You pay a $10 copayment to see your primary care physician. You pay a $20 copayment to see a specialist.
Flu Vaccine	You pay $0 for the Influenza vaccine. No referral necessary for network providers. An office visit copayment will apply. You pay a $10 copayment to see your primary care physician. You pay a $20 copayment to see a specialist.
Hepatitis B Vaccine (For members at intermediate or high risk.)	You pay $0 for the Hepatitis B vaccine. An office visit copayment will apply. You pay a $10 copayment to see your primary care physician. You pay a $20 copayment to see a specialist.
MedicareComplete Part B Prescription Drugs **Medicare Part B Prescription Drugs — Covered under the Medical Benefit (Includes coverage for immunizing agents, biological sera, blood or blood plasma, or drugs (except insulin) prescribed for intravenous or intramuscular use or administration when authorized by your doctor and in accordance with Medicare guidelines.)**	
Medicare Part B Covered Immunosuppressive Drugs (Following a Medicare-approved organ transplant in accordance with Medicare guidelines.)	You pay 20% coinsurance for covered immunosuppressive drugs.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Medicare Part B Covered Oral Chemotherapy Drugs Including Anti-nausea Drugs	You pay 20% coinsurance for self-administered Medicare-approved oral chemotherapy drugs, including anti-nausea drugs for up to a 30-day supply, when prescribed by your doctor as an anti-cancer chemotherapeutic agent.
Medicare Part B Covered Inhalation Solutions	You pay 20% coinsurance for inhalation solutions, such as Alupent, Isuprel, Metaprel, Proventil, etc. at a network pharmacy. (Hand-held metered dose inhalation units are part of the Medicare Part D Prescription Drug Benefit.)
Outpatient Injectable Medications — Self-Administered	You pay 20% coinsurance for Medicare-covered benefits.
Outpatient Injectable Medications — Administered in a Physician's Office (Medicare-covered drugs that are not self-administered by the patient, and are injected while receiving physician services, including chemotherapy, anti-emetics drugs and infusion medications.)	You pay 20% coinsurance for Medicare-covered benefits. An office visit copayment will apply.
Hemophilia Clotting Factors	You pay 20% coinsurance for Medicare-covered benefits.
Antigens (Treatment by RN, injection, including serum.)	You pay 20% coinsurance for Medicare-covered benefits.
Allergy Testing and Treatment by a Physician	You pay 20% coinsurance for Medicare-covered benefits.
Additional Benefits	
Chiropractic Services	
▪ **Medicare-covered (Manual manipulation of the spine to correct subluxation.)**	You pay a $20 copayment for Medicare-covered benefits.
▪ **Routine (non Medicare-covered)**	You pay 100% of the cost for routine chiropractic services.

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Dental Services	
▪ **Medicare-covered (Services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of cancer.)**	You pay a $20 copayment for Medicare-covered dental services when referred by your network primary care physician.
▪ **Preventive (non Medicare-covered)**	You pay 100% of the cost for preventive dental services.
▪ **Routine (non Medicare-covered)**	You pay 100% of the cost for routine dental services.
Foot Care	
▪ **Medicare-covered foot care (Includes only those services that meet Medicare criteria for the care of medical conditions affecting the lower limbs, including routine foot care.)**	You pay a $20 copayment for each Medicare-covered visit.
▪ **Routine (non Medicare-covered)**	You pay 100% of the cost for routine foot care services.
Hearing Services	
▪ **Medicare-covered diagnostic hearing exam**	You pay a $20 copayment for each Medicare-covered hearing exam with a network provider.
▪ **Routine Hearing Test and Hearing Aids (non Medicare-covered)**	You pay $20 of the cost for routine hearing tests. You have a $1,000 allowance per calendar year for hearing aids at a network provider.
Temporomandibular Joint Dysfunction (TMJ)	You pay 20%; MedicareComplete Retiree Plan pays 80%; lifetime maximum benefit of $1,000 (when Medically Necessary).

BENEFIT DESCRIPTION	MedicareComplete Retiree Plan (Enrolled in Medicare Parts A and B)
Vision Services	
Eye care – medical need	
▪ **Medicare-covered eye exam**	You pay a $20 copayment for Medicare-covered diagnosis and treatment for diseases and conditions of the eye with a network provider. (Medicare-covered annual glaucoma screening included for members at high risk for glaucoma, members with a family history of glaucoma or members with diabetes.)
▪ **Medicare-covered eyewear**	You pay $0 for one pair of Medicare-covered lenses or contact lenses after each cataract surgery. Allowance for Medicare-covered frames may apply.
Routine Vision Services (non Medicare-covered)	
▪ **Routine eye exam (refraction)**	You pay a $20 copayment for one routine eye exam per year (refractions).
▪ **Routine eyewear or contact lenses**	You pay 100% of the cost for routine eyewear or contact lenses beyond the allowance given. You have a $50 Frames and Lenses OR contact lenses allowance every 12 months. Your medical plan covers one eye exam per year and medically necessary glasses or lenses following cataract surgery. Your Routine Prescription Eyewear benefit provides a routine eye exam, eyeglasses or contact lenses for routine vision correction. If you need the services of an eye specialist, you should call MedicareComplete Customer Service at 1-866-622-8055 (TTY 1-888-685-8480), 8 a.m. to 8 p.m. local time, Monday through Sunday, for the nearest Participating Provider.
Annual Routine Physical Examinations (non Medicare-covered)	You pay a $10 copayment for annual routine physical examinations, limited to one per calendar year.
Optum® NurseLine	You pay $0 for calls to the NurseLine, available 24 hours a day, every day to help you with health and medical questions. Simply call 1-877-365-7949, or for the hearing impaired, call the National Relay Center at 1-800-855-2880 and ask for 1-877-365-7951.

SECTION V: MedicareComplete® Part D Prescription Drugs — Low Option

Your Medicare Advantage Plan includes a Medicare-approved Part D drug benefit.

You automatically receive Medicare Part D prescription drug coverage as part of your benefit plan.

SecureHorizons® Standard Retiree Formulary applies to both retail and mail order prescriptions.

$0–$4,050 Out-of-Pocket Costs

Retail

- You pay a $20 copayment for Tier I preferred generic drugs.
- You pay a $40 copayment for Tier II preferred brand name drugs.
- You pay a $40 copayment for Tier III* non-preferred drugs.
- You pay a $40 copayment for Tier IV specialty drugs per Prescription Unit or up to a 30-day supply

Mail Service

- You pay a $40 copayment for Tier I preferred generic drugs.
- You pay an $80 copayment for Tier II preferred brand name drugs.
- You pay an $80 copayment for Tier III* non-preferred drugs.
- You pay an $80 copayment for Tier IV specialty drugs per up to a 90-day supply through our contracted Mail Service Pharmacy.

*** Exception Policy**

The MedicareComplete Drug Formulary contains many commonly prescribed drugs. During the course of your medical care, there may be instances when your doctor prescribes a drug that is not included on the Formulary, a drug that has Formulary limits or restrictions, or a pharmacist tells you the drug your doctor prescribed is not on the Formulary. Under certain circumstances, we may grant exceptions to Formulary coverage rules. **In order to request a Formulary exception, you must have a statement from your doctor supporting your request.** You may request an exception for the following reasons:

- A drug that is medically necessary to treat your medical condition is not included on the Formulary and a therapeutic substitute is not available.
- The Formulary quantity limits for your prescribed drug are not high enough to treat your medical condition.

All exceptions to the Formulary coverage rules are based on medical necessity.

If you receive a coverage exception for a drug that is not included on the Formulary, you must pay your benefit plan's appropriate copayment or coinsurance.

If we approve your Formulary exception request, the approval is valid for the remainder of the calendar year, as long as your doctor continues to prescribe the drug and as long as the drug continues to be safe and effective in treating your medical condition. If we deny your Formulary exception request, you may appeal our decision.

After Your Yearly Out-of-Pocket Costs Reach: $4,050

You pay the greater of $2.35 for generic or a preferred brand drug that is a multi-source drug, and $5.60 for all other drugs, or 5% coinsurance once your total out-of-pocket costs reach $4,050.

Part D Drug Benefits Questions and Answers

Your MedicareComplete Retiree Plan benefit plan includes a Medicare Part D drug benefit. Because you are enrolled in a MedicareComplete Retiree Plan benefit plan that offers Medicare Part D drug coverage, you may not enroll in any other Medicare Part D drug plan while a member of our plan. If you enroll in any other Medicare Part D drug plan, you will be disenrolled from the MedicareComplete Retiree Plan. Your enrollment in MedicareComplete Retiree Plan does not affect your coverage for drugs covered under Medicare Part A and Part B.

What Is the MedicareComplete Drug Formulary?

The MedicareComplete Drug Formulary is a list of Medicare Part D drugs that your contracting providers may use in your medical treatment. It contains many brand name and generic drugs. Most therapeutic classes (for example, antibiotics, anti-depressants, anti-hypertensives) are covered, and many commonly prescribed drugs are included. While we will generally cover the drugs listed on the Formulary, the presence of a drug on the Formulary does not guarantee that your doctor will prescribe that drug to treat your particular medical condition.

Drugs on the Formulary are organized into four different drug tiers, or groups of different drug types. The copayment or coinsurance amounts you pay for a Covered Drug depend on the drug tier for your particular drug.

Under My MedicareComplete Retiree Plan, Can the Drugs I Take Be Removed from the Formulary?

In general, if you are a MedicareComplete Retiree Plan member taking a drug on our Formulary that was covered at the beginning of the calendar year, we will not discontinue or reduce coverage for your drug **during the calendar year. There are two exceptions to this policy:**

- When Generic drugs become available, they may be dispensed in place of Brand Name drugs on the Formulary.
- In the event a drug is determined to be unsafe, we will immediately remove the drug from the Formulary.

Removing a drug from the Formulary will not affect members currently taking the drug. The drug will continue to be available with the same Copayments or Coinsurance for the remainder of the calendar year.

How Can the Formulary Change During the Calendar Year?

The Formulary is updated periodically throughout the year, and the list of drugs may change as drugs are added or deleted from the list. If you do not see your current drugs listed, or if you would like an updated Formulary, please visit our Web site at *www.securehorizons.com* or call Customer Service at 1-866-622-8055 (TTY 1-888-685-8480), 8 a.m. to 8 p.m. local time, Monday through Sunday.

The Formulary may change without notice during the calendar year; however, we will notify you in writing if a Formulary drug you are taking:

- is removed from the Formulary
- has new Prior Authorization requirements
- has reduced quantity limits
- has Step Therapy restrictions
- moves to a higher Copayment or Coinsurance tier

We will notify you at least sixty (60) days prior to a change to a Formulary drug that you are currently taking when the criteria listed above are met. In the event a drug is determined to be unsafe, we will immediately remove the drug from the Formulary.

When Generic drugs become available, they may be dispensed in place of Brand Name drugs on the Formulary.

What Are Covered Drugs?

Covered Drugs are drugs included on the MedicareComplete Drug Formulary and drugs that are not included on the Formulary but have been determined by SecureHorizons to be medically necessary through the exception process.

Where To Have Your Prescriptions Filled

You must use network pharmacies. If you have your prescriptions filled at out-of-network pharmacies, you will most likely have to pay the full cost for your drugs. We contract with many of the largest retail pharmacy chains as well as many local independent pharmacies. You may have your prescriptions filled at any of our network pharmacies nationwide. Also included in our network of contracted pharmacies are long-term care pharmacies, Indian Health Service/Tribal/Urban Indian Health Program (I/T/U) pharmacies and home infusion pharmacies. Sometimes, a particular pharmacy may leave our contracting network. In this situation, have your prescription filled at another network pharmacy, or you will most likely have to pay the full cost of prescriptions filled at a pharmacy that has left our network. Once you have your prescription filled at one network pharmacy, you are not required to continue going to the same network pharmacy to fill your prescriptions. You may go to any of our network pharmacies.

Generally, we will only cover drugs obtained from out-of-network pharmacies under limited circumstances when a network pharmacy is not available. If you are away from home and have an urgent or emergency situation that requires a prescription, and you do not have access to a network pharmacy, you may have your prescription filled at any pharmacy. You may also have your prescriptions filled at an out-of-network pharmacy in the following situations: 1) if you are unable to get a Covered Drug in a timely manner, because there are no 24-hour network pharmacies within a reasonable driving distance; 2) if your Covered Drug is not carried at a network pharmacy or through mail service (for example, high cost or unique drugs); 3) if you need a prescription while traveling in the United States because you become ill, lose or run out of your prescription drug; 4) if you are getting a vaccine that is medically necessary but not covered by Medicare Part B; 5) if you receive certain Covered Drugs administered in your doctor's office.

If you do go to an out-of-network pharmacy for any of the reasons listed above, you may have to pay the full cost of the Covered Drugs when you fill your prescription (instead of paying the usual copayment or coinsurance). This is because when you fill a prescription at a network pharmacy, the claim is automatically submitted to us by the pharmacy; however, some out-of-network pharmacies may not be able to submit the claim directly to us. You may be responsible for paying the difference between what we would pay for a prescription filled at a network pharmacy and what the out-of-network pharmacy charged for your prescription. We will reimburse you for the cost of the prescription, minus the applicable copayment or coinsurance. Keep your receipt for proof of purchase and call Customer Service at 1-866-622-8055 (TTY 1-888-685-8480), 8 a.m. to 8 p.m. local time, Monday through Sunday, to request a claim form and to receive instructions on filing a claim. If you receive a bill from an out-of-network pharmacy, **do not pay the bill,** but submit it to us for processing and determination of your liability, if any.

If possible, please call Customer Service at 1-866-622-8055 (TTY 1-888-685-8480), 8 a.m. to 8 p.m. local time, Monday through Sunday, before filling a prescription at an out-of-network pharmacy. The Customer Service representative can advise you if there is a network pharmacy in your area where you can fill your prescription.

For a complete list of network pharmacies in your area, please call Customer Service at 1-866-622-8055 (TTY 1-888-685-8480), 8 a.m. to 8 p.m. local time, Monday through Sunday, and ask for a copy of the Pharmacy Directory or visit our Web site at *www.securehorizons.com*.

How To Fill a Prescription at a Network Pharmacy

Take your prescription, written by your doctor, to a SecureHorizons network pharmacy.

Present your MedicareComplete Retiree Plan membership card at the network pharmacy.

Once your order is filled, pay your pharmacy copayment or coinsurance for up to a 30-day supply of the prescription drug.

The retail network pharmacy that you choose may allow you to receive a 90-day supply for the applicable copayments (for example, 3 copayments) or coinsurance for your Covered Drug.

Preferred Mail Service Pharmacy

Save money with our convenient mail service pharmacy. The mail service pharmacy offered through Prescription Solutions, our preferred contracting pharmacy provider, provides convenient service and savings on drugs that you take on a regular basis (i.e., maintenance drugs).

Your prescription(s) will be reviewed and filled by a licensed pharmacist and will be mailed to your home to arrive approximately 7 working days from the day Prescription Solutions receives your order. All orders are shipped in discreetly labeled packages, and there are no shipping or handling charges.

Note: Drugs used for short-term or acute illnesses, such as antibiotics, are not available through the mail service pharmacy.

How To Fill a Prescription Through a Mail Service Pharmacy

You may fill a prescription through our preferred mail service pharmacy by calling Prescription Solutions at 1-877-889-6358 (TTY 1-800-498-5428), 24 hours a day, 7 days a week. Please see the Pharmacy Program booklet for details on how to fill a prescription through Prescription Solutions or call Customer Service at 1-866-622-8055 (TTY 1-888-685-8480), 8 a.m. to 8 p.m. local time, Monday through Sunday.

What Is an Explanation of Benefits?

The Explanation of Benefits is a report we mail to you each month when you use your MedicareComplete Retiree Plan Medicare Part D prescription drug benefit. The Explanation of Benefits shows the total amount of copayments and coinsurance you have paid that month on Covered Drugs, together with the total amount we have paid that month for your drugs.

We record your out-of-pocket costs on claims you submit for Covered Drugs until your out-of-pocket costs reach $4,050 in a calendar year. Once your out-of-pocket costs reach $4,050 in a calendar year, you pay significantly reduced copayments and coinsurance amounts for Covered Drugs.

The Explanation of Benefits contains the following information:

- A list of prescriptions you had filled during the previous month, including the amount you paid for each prescription.
- A notification of any unfavorable changes to the Formulary that affect the drugs you are taking, with at least a sixty (60) day notice.
- A year-to-date summary of your prescription drug costs, including the amounts you and SecureHorizons have paid that count toward the annual initial coverage limit and toward your out-of-pocket costs.
- Information about how to use the exception process and how to appeal our coverage determinations.

If you do not receive an Explanation of Benefits in the mail, please call Customer Service at 1-866-622-8055 (TTY 1-888-685-8480), 8 a.m. to 8 p.m. local time, Monday through Sunday.

Prior Authorization for Selected Drugs on the Formulary

Selected drugs on the Formulary must be prior authorized by us to determine that they are medically necessary and being prescribed according to treatment guidelines consistent with standard professional practice.

Quantity Limits

For certain drugs on the Formulary, we limit the amount of the drug available per prescription. While the standard prescription unit for oral drugs is a 30-day supply, certain drugs have quantity limits that do not use the standard 1-month or 3-month supply. Also, for drugs on the Formulary that could be habit-forming, a quantity limit is set at less than a 30-day supply for your protection and safety. This means you will need to get approval from us before you fill your prescription. If you do not have approval, we may not cover the drug.

Step Therapy Requirements

For selected drugs on the Formulary, we require that you try a certain drug to treat your medical condition before you can be covered for another drug for your condition. For example, we may not cover drug B until you have first tried drug A. If drug A does not work for your medical condition or is inappropriate, we will then cover drug B.

Medication Therapy Management Programs

We provide a Medication Therapy Management (MTM) program at no additional cost for members who have multiple medical conditions, who are taking many covered Medicare Part D prescription drugs and who have high drug costs. This program is required by the Centers for Medicare & Medicaid Services (CMS) for all plans offering Medicare Part D Plan prescription drug coverage and is designed to improve medication use and reduce medication errors. Please be aware this program does not provide financial help such as copayment or coinsurance assistance and does not conduct clinical studies.

The MTM program is provided to members who meet specific criteria. We will determine if you meet the criteria. If you qualify, we will notify you.

Through this program, we will provide you with information about medications that are used in certain conditions. Also, we will identify possible medication errors as well as ways to better manage certain conditions through appropriate medication use.

Drug Utilization Review

We conduct drug utilization reviews for all of our members to make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribe their medications. We conduct drug utilization reviews on a regular basis by reviewing our records. During these reviews, we look for medication problems such as: possible medication errors; duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition; drugs that are inappropriate because of your age or gender; possible harmful interactions between drugs you are taking; drug allergies; drug dosage errors.

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Exception Policy

The MedicareComplete Drug Formulary contains many commonly prescribed drugs. During the course of your medical care, there may be instances when your doctor prescribes a drug that is not included on the Formulary, a drug that has Formulary limits or restrictions, or a pharmacist tells you the drug your doctor prescribed is not on the Formulary. Under certain circumstances, we may grant exceptions to Formulary coverage rules. **In order to request a Formulary exception, you must have a statement from your doctor supporting your request.** You may request an exception for the following reasons:

- A drug that is medically necessary to treat your medical condition is not included on the Formulary and a therapeutic substitute is not available.
- The Formulary quantity limits for your prescribed drug are not high enough to treat your medical condition.

All exceptions to the Formulary coverage rules are based on medical necessity.

If you receive a coverage exception for a drug that is not included on the Formulary, you must pay your benefit plan's appropriate copayment or coinsurance.

If we approve your Formulary exception request, the approval is valid for the remainder of the calendar year, as long as your doctor continues to prescribe the drug and as long as the drug continues to be safe and effective in treating your medical condition. If we deny your Formulary exception request, you may appeal our decision.

What if My Drug Is Not on the Formulary?

If your drug is not included on the Formulary, please call Customer Service at 1-866-622-8055 (TTY 1-888-685-8480), 8 a.m. to 8 p.m. local time, Monday through Sunday, and ask if your drug is covered. If we do not cover your drug, you have two options:

- Ask Customer Service for a list of similar drugs that are on the Formulary. When you receive the list, show it to your doctor and ask him or her to prescribe a similar drug that is on the Formulary.
- You can ask us to make an exception and cover your drug.

As a new MedicareComplete Retiree Plan member, you may be taking drugs that are not included on our Formulary. You may also be taking a drug that is on our Formulary, but the drug has prior authorization requirements or quantity limits. In these cases, you should discuss your options with your doctor. Your doctor may recommend that you switch to a different drug or ask us for a Formulary exception. In certain cases, we will cover your current drug during your first 90 days as a MedicareComplete Retiree Plan member.

For each of your current drugs that are not on our Formulary or have Formulary restrictions, we will cover a temporary 30-day transitional supply of the drug (unless your prescription is for fewer days) at network Pharmacies. After the first 30-day supply, we will not pay for these drugs, even if you have been a member for less than 90 days.

Important note to residents of long-term care facilities: We will cover a temporary, 31-day transitional supply (unless your prescription is for fewer days). We will cover more than one refill of these drugs for your first 90 days as a MedicareComplete Retiree Plan member. If you need a drug that is not on our Formulary or that has Formulary restrictions, but you have been a MedicareComplete Retiree Plan member for more than 90 days, we will cover a 31-day emergency supply of that drug (unless you have a prescription written for fewer days) while you pursue a Formulary exception.

What Is a Coverage Determination?

A Coverage Determination is a decision made by us regarding coverage for Medicare Part D prescription drugs. Coverage Determinations include requests for exceptions, as described above, and requests for coverage in the following situations:

- When you have been denied a Medicare Part D prescription drug that you believe should be covered by us.
- When payment has been denied for a Medicare Part D prescription drug you have received and you believe should be covered.
- When the coverage for your Medicare Part D prescription drug has been reduced or removed from the Formulary.
- When you have filled a prescription at an out-of-network pharmacy and you want reimbursement.

You, your doctor or someone you name may request a Coverage Determination. The person you name would be your appointed representative. You may name a relative, a friend, advocate, doctor or someone else to act for you. Please see the Evidence of Coverage for more information on how to name an appointed representative.

You also have the right to have an attorney ask for a Coverage Determination on your behalf. You may contact your own attorney, or get the name of an attorney from a referral service.

Coverage Determination Timeframes:

- **Standard Coverage Determinations must be completed within seventy-two (72) hours**
- **Expedited Coverage Determinations must be completed within twenty-four (24) hours**

Standard Coverage Determination

Standard Coverage Determination requests are appropriate in situations such as reimbursement for Medicare Part D prescription drugs that you have already received. In this situation, you generally will be notified of the decision within seventy-two (72) hours of your request.

Standard Coverage Determination requests for Formulary exceptions, drug tier exceptions or exceptions from drug quantity limits or step therapy requirements must be Medically Necessary and supported with a physician's statement. In these situations, we must make a Coverage Determination within seventy-two (72) hours after receiving your physician's supporting statement and must notify you of the decision. If we do not approve your request (an adverse Coverage Determination), the written notice will state the reasons for the denial and inform you of your right to file an Appeal.

If you do not receive a Coverage Determination notification within seventy-two (72) hours of your request, we must submit the request to an Independent Review Entity (IRE) for review within twenty-four (24) hours of the expiration of the required timeframe.

If your request for a standard Coverage Determination regarding an exception is decided in your favor, we will notify you and authorize the drug you requested within seventy-two (72) hours after receiving your physician's supporting statement. If your request for a standard Coverage Determination regarding a reimbursement for a drug that you have already received is decided in your favor, we must notify you and send you payment no later than thirty (30) days after the receipt of your request.

Expedited 24-Hour Coverage Determination

You may request and receive an expedited twenty-four (24)-hour Coverage Determination in situations in which waiting for a decision within the standard timeframe could seriously jeopardize your life, health, or your ability to function. If we decide, based on medical criteria, that your situation requires an expedited Coverage Determination, or if any doctor calls or writes in support of your request for an expedited Coverage Determination, we will issue a decision as expeditiously as possible, but no later than twenty-four (24) hours after receiving the request.

If you request an expedited twenty-four (24)-hour Coverage Determination without support from a physician, we will determine if your health situation requires the expedited twenty-four (24)-hour Coverage Determination. If we determine that your health situation does not require an expedited twenty-four (24)-hour Coverage Determination, you will be notified. The written notification may explain that your expedited Coverage Determination request lacked necessary physician support. The notification will explain that you have the right to file a Grievance based on our denial of your request for an expedited review and that your request will be reviewed within the standard seventy-two (72)-hour timeframe.

If we determine that your request for an expedited Coverage Determination is appropriate, but you do not receive a decision from us within twenty-four (24) hours of your request, your request will automatically be elevated to the second level of an Appeal and will be reviewed by an Independent Review Entity (IRE).

If your expedited twenty-four (24)-hour Coverage Determination involving an exception request is decided in your favor, we must notify you and authorize or provide the drug you requested within twenty-four (24) hours after receiving your physician's supporting statement.

How To Request a Standard Coverage Determination

To request a Standard Coverage Determination, you or your authorized representative may call, write, or fax us.

Call: 1-866-622-8055
8 a.m. to 8 p.m. local time
Monday through Sunday
We will document your request in writing.

TTY: 1-888-685-8480
8 a.m. to 8 p.m. local time
Monday through Sunday
We will document your request in writing.

Write: Customer Service
Coverage Determinations
P.O. Box 6006
Cypress, CA 90630
Mailstop: CA124-0157

Fax: Coverage Determinations
1-800-346-0930

Note: The Customer Service representative will record the date and time of all telephone or fax requests for Coverage Determinations received on Saturday or Sunday or before or after business hours Monday through Friday. For standard Coverage Determination requests, the seventy-two (72)-hour period will begin at the time the request is received.

How To Request an Expedited Coverage Determination

To request an expedited Coverage Determination, you or your authorized representative may call, fax or visit us. **Please indicate that you want an expedited twenty-four (24)-hour Coverage Determination when you speak to the Customer Service representative or send the fax.**

During normal business hours, call or fax:

Call: 1-866-622-8055
8 a.m. to 8 p.m. local time
Monday through Sunday
We will document your request in writing.

TTY: 1-888-685-8480
8 a.m. to 8 p.m. local time
Monday through Sunday
We will document your request in writing.

Fax: Coverage Determinations
1-800-346-0930

SECTION VI: Your MedicareComplete® Retiree Plan Questions Answered

We know you may still have questions about how to get the most out of a MedicareComplete® Retiree Plan, and we are here to help you through the process. The frequently asked questions in this section will help you understand how our plans can help you meet your health care coverage needs.

Questions and Answers

1. **Is my doctor on the plan? Can you give me the provider number for my doctor?**

   In addition to the provider directory, updated information about our contracting provider network is also available online at *www.securehorizons.com*. This resource provides easy access to information about primary care physicians and specialists, including their specialties and office locations. The online provider directory is updated regularly to provide you with the current list of providers.

   If you would like assistance choosing or changing a contracting primary care physician, please call Customer Service at 1-866-622-8055 (TTY 1-888-685-8480), 8 a.m. to 8 p.m. local time, Monday through Sunday. If you are already a member, please call the number on the back of your membership card.

   Important Note: We shall attempt to provide continuing availability of physicians, hospitals and other providers listed in this directory. However, physicians, hospitals and other providers will occasionally become unavailable, due to lack of capacity (i.e., they are unable to see more patients) or termination of a contract. We cannot guarantee that any specific physician, hospital or other provider will be available to you during the term of your enrollment, although the vast majority are available.

2. **Are my drugs covered on the plan?**

   The drug formularies are updated throughout the year, and the list of drugs may change as drugs are added or deleted from the list. If you want to confirm your prescription drug(s) are on the formulary for your plan, please call Customer Service at 1-866-622-8055 (TTY 1-888-685-8480), 8 a.m. to 8 p.m. local time, Monday through Sunday. If you are already a member, please call the number on the back of your membership card. You may also see the current formulary at *www.securehorizons.com*. Click on "Pharmacy", then the "Search Drug List" link.

3. **Will I get a separate ID card to go to the pharmacy?**

   As a member of a SecureHorizons® plan with pharmacy drug coverage, you will receive only one ID card which can be used for both medical care and at the pharmacy.

4. **Will the plan cover me if I travel?**

   Emergency and Urgently Needed Services never require Prior Authorization. No matter where you are in the world, you'll be covered in these cases for each Medicare-covered visit. (Emergency and Urgently Needed Services copayments may apply and may vary.) However, be sure to contact your Contracting Medical Provider or our Customer Service number located on the back of your

membership card within 48 hours, or as soon as reasonably possible, so the appropriate people can help coordinate any follow-up you may need.

5. **What is the cost of the plan? What is my monthly premium?**

   For specifics about your plan premiums, please refer to the ADOA Enrollment Guide.

6. **What are my current benefits through my employer?**

   See the Summary of Benefits Table provided in this booklet: Section II for the High Option and Sectionn IV for the Low Option. If you have questions, please call Customer Service at 1-866-622-8055 (TTY 1-888-685-8480), 8 a.m. to 8 p.m. local time, Monday through Sunday. If you are already a member, please call the number on the back of your membership card.

7. **If I decide to drop my current retiree coverage, am I able to go back to it in the future?**

   ADOA does allow re-enrollment under the current retiree coverage with a qualifying event. Please refer to the ADOA Enrollment Guide for additional enrollment information.

8. **How does my current coverage compare to your individual plans?**

   Typically, group-sponsored benefit plans provide richer benefits than those available to individuals not associated with a group. For specifics about your plan benefits, see Section II for the High Option and Section IV for the Low Option. For plan premiums, please refer to the ADOA Enrollment Guide.

9. **I need assistance completing my application.**

   For more information on completing the ADOA Enrollment Application, please call ADOA Member Services at (602) 542-5008, from 8 a.m. to 5 p.m. MST, Monday through Friday.

10. **Where do I send my completed application?**

    You can send your completed application in the business reply envelope included in your packet or mail it to:

    Arizona Department of Administration
    Attention: Benefits Office
    100 N. 15th Ave., Ste. 103
    Phoenix, AZ 85007

SECTION VII: Plan Limitations and Exclusions

Medical Plan Limitations and Exclusions

(The Limitations and Exclusions below are for the Medical Plan only, and do not include Medicare Part D Prescription Drug Limitations and Exclusions. Please see page 82 for your Part D Prescription Drug benefit Limitations and Exclusions.)

All services, procedures, treatments, and supplies for medical care and conditions within each of the following classifications shall be limited or excluded from coverage under this plan as specifically described below (copayments and coinsurance will apply where appropriate):

Limitations

1. Services, procedures, treatments, and supplies rendered outside the MedicareComplete® service area are excluded, except for emergency, Urgently Needed Services, out-of-area renal dialysis and routine travel renal dialysis or covered services for which MedicareComplete allows you to self-refer to contracting medical providers. Out-of-area follow-up care will be covered as long as care provided continues to meet the definition for either emergency or urgently needed care. Routine travel dialysis must be provided at a Medicare-certified facility within the United States.
2. Biofeedback is excluded, except when Medicare criteria are met.
3. Homemaker services are excluded, except those covered in accordance with Medicare guidelines.
4. Cosmetic surgery is excluded, except for such plastic and reconstructive surgery as may be necessary due to accidental injury or to improve the function of a malformed body part. Breast reconstruction is covered only following a mastectomy, in accordance with Medicare guidelines.
5. A private room in a hospital or a skilled nursing facility is not covered, unless medically necessary.
6. Long-term services beyond that which Medicare would cover are excluded, except as determined by SecureHorizons® to be less costly alternatives to the basic minimum benefit.
7. Bariatric surgical procedures are not covered for the sole purpose of weight loss and/or weight management. Bariatric surgery will only be covered when medically necessary for the treatment of morbid obesity, in accordance with CMS National Coverage Determination or Local Carrier Determination guidelines. In the absence of either of these determinations, SecureHorizons will use scientific, evidence-based criteria, such as the National Institutes of Health (NIH) guidelines, to determine the medical necessity of surgical treatment for morbid obesity. Prior to this consideration by SecureHorizons, the Member may be required to participate in a SecureHorizons-sponsored/approved program for no less than six (6) months. This program includes, but is not limited to, a multidisciplinary nonsurgical approach of supervised diet, exercise and behavioral modification. SecureHorizons reserves the right to designate the providers and facilities within

the member's contracting medical group/IPA/network based on a number of factors, including training and experience, cost and surgical results. Surgical treatment for morbid obesity and services related to Bariatric surgery are subject to prior approval by the member's contracting medical group/IPA or the/a SecureHorizons medical director.

8. Dental splints, dental prosthesis or any dental treatment for the teeth, gums or jaw or dental treatment related to temporomandibular joint syndrome (TMJ) are covered only when Medicare criteria are met.
9. Orthopedic shoes are covered only when they are part of a leg brace and are included in the orthopedist's charge for the brace. Therapeutic shoes and supportive devices for the feet are covered for members suffering from diabetic foot disease, in accordance with Medicare guidelines.
10. For most plans, routine foot care is excluded, except in accordance with Medicare guidelines. (Refer to Summary of Benefits table, page 14 for the High Option and page 46 for the Low Option.)
11. Beneficiaries who have Chronic Renal Disease (CRD) or End-Stage Renal Disease (ESRD) may enroll in MedicareComplete Retiree Plan if certain criteria are met. Please refer to Section 2 of the Evidence of Coverage and Disclosure Information. Beneficiaries who join MedicareComplete and later develop CRD or ESRD will continue to be covered by MedicareComplete Retiree Plan.
12. Chiropractic services are limited to the treatment of subluxation of the spine upon referral from the member's contracting primary care physician and are covered in accordance with Medicare guidelines. (Refer to Summary of Benefits table, page 14 for the High Option and page 45 for the Low Option.)
13. Dental Services are excluded, except those dental services covered under the MedicareComplete Retiree Plan medical benefit. (Refer to Summary of Benefits table, page 14 for the High Option and page 45 for the Low Option.)
14. Aqua therapy is covered only as part of a multi-modality authorized treatment plan with a licensed therapist in attendance.
15. Proton beam therapy for the medically appropriate treatment of prostate cancer is a covered service. Prior authorization must be obtained for all treatment in order for the proton beam therapy to be considered a covered service. Coverage for proton beam therapy for the treatment of prostate cancer is limited to a maximum of the Original Medicare allowable amount for conformal 3D proton beam therapy treatments for prostate cancer. Coverage is subject to coinsurance, including, but not limited to, coinsurance for radiation therapy. Members are responsible for any amounts in excess of Original Medicare allowable amounts and for any travel or other costs associated with obtaining proton beam therapy treatment of prostate cancer.
16. Substance abuse detoxification and rehabilitation are covered in accordance with Medicare guidelines.
17. Abortion is excluded, except for cases resulting in pregnancies from rape or incest or that endanger the life of the mother.
18. Hearing exams and devices are covered in accordance with Medicare guidelines. (Refer to Summary of Benefits table, page 15 for the High Option and page 46 for the Low Option.)

19. Heart transplants, including Ventricular Assist Devices (as both "a bridge to transplant" and for "destination therapy"), are only covered when the procedure is performed at a SecureHorizons National Preferred Transplant Network Facility or other SecureHorizons authorized transplant facilities when determined Medically Necessary by the SecureHorizons National Preferred Network Medical Director or designee.

20. MedicareComplete Retiree Plan covers outpatient injectables on the MedicareComplete Retiree Plan list of outpatient injectables in accordance with Medicare guidelines. Prior authorization is required and applicable coinsurance is required for a 30-day supply, course of therapy or treatment of an acute episode, whichever is shorter. No more than a 30-day supply will be dispensed at one time and must be obtained through a contracting provider. **Note:** The outpatient injectable copayment applies regardless of *where* the outpatient injection is administered, including, but not limited to, a physician's office and/or outpatient clinic.

21. Your Plan Sponsor has elected prescription drugs as a supplemental benefit. (Refer to Summary of Benefits table, page 15 for the High Option and page 46 for the Low Option.)

22. Smoking cessation products and treatments are covered in accordance with Medicare guidelines.

Exclusions

The following services, procedures, treatments and supplies are Excluded from coverage:

1. Any service, procedure, treatment, supply or medication not specifically included in the Retiree Benefits Summary; any service, procedure, treatment, supply or medication not provided, arranged or authorized by a contracting medical provider or SecureHorizons (except for emergency or Urgently Needed Services) or services, procedures, treatments, and supplies obtained prior to a member's start date of coverage or after termination of coverage.

2. All items and services, procedures, treatments, and supplies that are not medically necessary to treat an illness or injury, and which do not meet Medicare program standards.

3. Procedures, services, supplies and medications, until they are reviewed for safety, efficacy and cost-effectiveness and approved by SecureHorizons.

4. Unless medically necessary to treat a medical illness or injury, elective or voluntary enhancement services, procedures, treatments, supplies and medications, including, but not limited to, services related to weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance.

5. Acupuncture.

6. Custodial care, which includes, but is not limited to, care that assists members in the activities of daily living, such as walking, getting in and out of bed, feeding, bathing, dressing and using the toilet; preparation of special diets; supervision of the administration of medication that is usually self-administered; and meals delivered to the member's home, regardless of the setting, which includes, but is not limited to, rest homes, a home for the aged, personal residences, assisted

living facilities, residential living or similar facilities.

7. Hospice services in a participating Medicare-certified hospice are not paid for by SecureHorizons, but are reimbursed directly by Medicare when provided by a Medicare-certified hospice. You remain enrolled in MedicareComplete Retiree Plan even though you have elected hospice coverage. SecureHorizons will be responsible to cover certain benefits not covered by Original Medicare. You may use your MedicareComplete Retiree Plan contracting doctor as your hospice-attending physician.
8. Complementary alternative medicine, tradition-based medicine and/or non-conventional medicine, except as covered by Medicare criteria for the treatment of an illness or disease. Examples include, but are not limited to, naturopathy, yoga, polarity, massage therapy, healing touch therapies and bioelectromagnetics.
9. Items and services determined by SecureHorizons or Medicare to be experimental or investigational and that do not qualify for Medicare coverage.
10. Private duty nursing care.
11. Nursing care on a full-time basis in your home.
12. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility and items for the home, such as air conditioners, air purifiers or other environmental equipment.
13. Services performed by immediate relatives or members of your household.
14. Reversal of sterilization procedures; sex change operations; conception by artificial means, which includes, but is not limited to, insemination procedures, in-vitro fertilization, zygote intrafallopian transfers and gamete intrafallopian transfers; and non-prescription contraceptive supplies and devices.
15. All forms of prescription medication for the treatment of sexual dysfunction, which includes, but is not limited to, erectile dysfunction, impotence and anorgasmy or hyporgasmy, except as included in the Medicare Advantage with Prescription Drug (MA-PD) benefit plan formulary that your Plan Sponsor may have elected.
16. Non-authorized emergency facility services for routine conditions.
17. Non-Medicare-covered organ transplants. Medical and hospital services of a donor when the recipient of an organ transplant is not a MedicareComplete Retiree Plan member.
18. Physical examinations or immunizations for the purpose of maintaining or obtaining employment, licenses, insurance, court hearings, travel, dietary counseling, weight reduction programs or for premarital and pre-adoption purposes, and/or other non-preventive reasons.
19. Drugs prescribed by a dentist or drugs used for dental treatment.
20. Government treatment for any services provided in a local, state or federal government facility or agency, except when payment under the plan is expressly required by federal or state law.
21. All services, procedures, treatments, medications and supplies related to Workers' Compensation claims.

22. Optional, additional or deluxe features or accessories to durable medical equipment, corrective appliances or prosthetics, which are primarily for the comfort or convenience of the member, or for ambulation primarily in the community, including home and car remodeling or modification.

23. Prenatal, maternity or post-partum care for a non-MedicareComplete Retiree Plan member acting as a surrogate.

24. SecureHorizons sometimes receives rebates from pharmaceutical manufacturers on medications covered under your MedicareComplete Retiree Plan medical benefit, which are not factored into the calculation of your coinsurance.

25. Non-emergency transportation.

26. Paramedic intercept service (advanced life support provided by an emergency service entity, such as a paramedic services unit, which does not provide ambulance transport), except when Medicare criteria are met.

27. The following exclusions apply to the SecureHorizons National Preferred Transplant Network:

    - Equipment and medication that is experimental/investigational and/or not Medically Necessary unless required by an Independent Review Entity.
    - Unauthorized or not prior authorized organ procurement and transplant related services. Transplants performed in a non-SecureHorizons National Preferred Transplant Network facility.
    - Transplant Services, including donor costs, when the transplant recipient is not a Member.
    - Artificial or non-human organs.
    - Transportation services for any day a member is not receiving medically necessary transplant services.
    - Transportation of any potential donor for typing and matching.
    - Transportation provided for the member and one-person escort to a SecureHorizons National Transplant facility, if the facility is greater than sixty (60) miles from the member's primary residence, or out of state, regardless of mileage, as prior authorized.
    - Food and housing will be provided for the member and one escort and is limited to $125 per day (excludes liquor and tobacco).
    - Food and housing for any day a member is not receiving medically necessary transplant services.
    - Storage cost for any organ or bone marrow, unless authorized by the SecureHorizons transplant Medical Director.
    - Services for which government funding or other insurance coverage is available.

28. If you participate in a clinical trial that meets Medicare requirements, those services are reimbursed directly by Medicare, and you will be responsible for any Medicare coinsurance amounts. You remain enrolled in MedicareComplete Retiree Plan and must continue to use your MedicareComplete Retiree Plan contracting doctor for your routine care unrelated to the clinical trial.
29. Injections which can be self-administered such as insulin are excluded, unless otherwise specified as covered by Medicare or MedicareComplete Retiree Plan.
30. LASIK, surgeries or other laser procedures for refractive error.
31. Routine vision services, including:
    - Routine vision services not described in this Retiree Benefits Summary.
    - Contact lenses, including fitting (K-reading) fee, except after cataract surgery.
    - Orthoptics or vision training and any associated supplemental testing.
    - Medical or surgical treatment of the eyes.
    - Plano lenses (non-prescription).
    - Two pairs of glasses in lieu of bifocals.
    - Subnormal (low) vision aids.
    - Replacement of lenses and frames which are lost or broken, except at the normal intervals when services are otherwise available.
    - Any eye examination or corrective eyewear required by an employer as a condition of employment.
    - Conditions covered by Workers' Compensation.
    - Any service or material provided by another vision or medical plan or non-contracting provider.
    - Cosmetic services and/or materials including, but not limited to, blended (no line) bifocal or trifocal lenses, oversize lenses (62 mm or greater), photochromic lenses, tinted lenses except Pink or Rose #1 or #2, progressive or multifocal lenses, the coating or laminating of the lens or lenses, UV (ultraviolet) lenses, polycarbonate/high-index lenses, anti-reflective coating, scratch-resistant coating, edge polish, cosmetic lenses and other cosmetic processes.
    - Eyeglasses when the change in prescription is less than .5 Dioptor.
    - Charges in excess of the reasonable and customary charges.
    - Charges incurred after the vision plan terminates or coverage has ended.
    - Experimental or non-coventional treatment or devices.

Your Plan Sponsor has elected routine vision services as a supplemental benefit. Please see page 32 for the High Option and page 63 for the Low Option of this Benefit Summary Booklet.

Note: Please refer to your MedicareComplete Retiree Plan Evidence of Coverage and Disclosure Information, and Retiree Benefits Summary Insert for detailed explanations.

MedicareComplete Drug Formulary Limitations and Exclusions

Plan D Outpatient Prescription Drugs Limitations and Exclusions

(Please note that these Limitations and Exclusions apply to Part D covered drugs only. Your Plan Sponsor may have elected to offer additional coverage for some prescription drugs that are normally excluded from your Part D coverage. Please refer to your formulary and/or formulary addendum to determine if your Plan Sponsor offers you additional drug coverage beyond the Medicare Part D coverage.)

Limitations

1. Drugs prescribed for non-FDA approved indications are excluded, unless prescribed in a manner consistent with a specific indication in one of the following compendia: *Drug Information for the Health Care Professional*, published by the United States Pharmacopeial Convention; DRUGDEX information system, American Medical Association Drug Evaluations, or the American Hospital Formulary Services edition of *Drug Information*.
2. We reserve the right to require Prior Authorization for certain drugs on the Formulary prior to dispensing.
3. Drugs prescribed by non-contracting doctors and/or drugs dispensed by non-contracting pharmacies are not covered (except for covered prescriptions required as a result of an emergency or urgently needed service for an acute condition).
4. Smoking cessation products and treatments are covered in accordance with Medicare guidelines.
5. Medicare Part A and Part B drugs are not covered under your Part D prescription drug coverage and are limited to those drugs available through your medical benefit.
6. Compounded drugs are limited to those drugs that are prior authorized and that have been determined by us to be medically necessary.
7. Drugs that apply to your covered drug costs or your Out-of-Pocket Costs are limited to drugs included on the Formulary and drugs that have been determined to be medically necessary.
8. Drugs not included on the Formulary and/or drugs that have not been determined by us to be medically necessary are limited to those drugs approved through our exception policy process.

Exclusions

1. Drugs that you purchase before you start or after you terminate your MedicareComplete Retiree Plan membership.
2. Elective or voluntary enhancement services, procedures, treatments, supplies and drugs, including, but not limited to:
   - Drugs used for sexual dysfunction, anorexia, hair growth, athletic performance, cosmetic purposes, anti-aging, weight loss or weight gain. Examples of these drugs include, but are not limited to: Cialis,® Viagra,® Levitra,® Xenical,® Meridia,® Retin-A,® Renova,® Vaniqa,® Propecia® and Lustra.®
   - Drugs used to promote fertility.
3. Drugs used for the symptomatic relief of coughs or colds.
4. Dietary supplements, including prescription vitamin and mineral products (except prenatal vitamins and fluoride), and health or beauty aids, herbal supplements and/or alternative medicine, except as covered by Medicare Part D.
5. Barbiturates.
6. Benzodiazepines.
7. Drugs for which the cost is recovered under any Workers' Compensation, Occupational Disease Law or from any state or government agency, or drugs furnished by any other drug or medical services for which there is no charge to the member.
8. Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale.
9. Non-prescription drugs, unless they are part of a Step Therapy protocol.
10. Drugs approved for sale prior to 1962 (known as DESI drugs) based on safety, but subsequently determined by the Food and Drug Administration to be less than effective.

SECTION VIII: Member Appeals and Grievances

Member Medical Plan Appeals and Grievances Process

The following procedures for appeals and grievances must be followed by SecureHorizons® in identifying, tracking, resolving and reporting all activity related to an appeal or grievance.

Member Appeals

Who can file an appeal?

An appeal may be filed by any of the following:

- You may file an appeal.
- Someone else may file the appeal for you on your behalf. You may appoint an individual to act as your representative to file the appeal for you by following the steps below:
  - — Provide SecureHorizons with your name, your Medicare number, and a statement which appoints an individual as your representative. (**Note:** You may appoint a physician or a Provider.) For example: "I _____ *[your name]* appoint _____ *[name of representative]* to act as my representative in requesting an appeal from SecureHorizons and/or CMS regarding the denial or discontinuation of medical services."
  - — You must sign and date the statement.
  - — Your representative must also sign and date this statement.
  - — You must include this signed statement with your appeal.
- A Non-Contracted Medical Provider may file a standard appeal of a denied claim if he or she completes a waiver of payment statement, which says he or she will not bill you regardless of the outcome of the appeal.

What is an appeal?

An appeal is a type of complaint you make when you want a reconsideration of a decision (determination) that was made regarding a service, or the amount of payment SecureHorizons pays or will pay for a service, or the amount an enrollee must pay for a service.

When can an appeal be filed?

You may file an appeal within sixty (60) calendar days of the date of the notice of the initial organization determination. For example, you may file an appeal for any of the following reasons:

- SecureHorizons refuses to cover or pay for services you think SecureHorizons should cover.
- SecureHorizons or one of the Contracting Medical Providers refuses to give you a service you think should be covered.
- SecureHorizons or one of the Contracting Medical Providers reduces or cuts back on services you have been receiving.
- If you think that SecureHorizons is stopping your coverage too soon.

Note: The sixty (60)-day limit may be extended for good cause. Include in your written request the reason why you could not file within the sixty (60)-day timeframe.

Where can an appeal be filed?

An appeal may be filed in writing directly to SecureHorizons Appeals and Grievance Unit at P.O. Box 6006, Cypress, CA 90630, Mailstop CA124-0157 or

a. You may contact Customer Service at 1-866-622-8055 (TTY 1-888-685-8480), 8 a.m. to 8 p.m. local time, Monday through Sunday.

b. You may fax your request to 1-800-346-0930.

Why file an appeal?

You may use the appeal procedure when you want a reconsideration of a decision (organization determination) that was made regarding a service or the amount of payment SecureHorizons paid for a service.

Fast Decisions/Expedited Appeals

You have the right to request and receive expedited decisions affecting your medical treatment in "Time-Sensitive" situations. A Time-Sensitive situation is a situation where waiting for a decision to be made within the timeframe of the standard decision-making process could seriously jeopardize:

- your life or health, or
- your ability to regain maximum function.

If SecureHorizons or your Primary Care Physician decides, based on medical criteria, that your situation is Time-Sensitive, or if any physician calls or writes in support of your request for an expedited review, SecureHorizons or your Primary Care Physician will issue a decision as expeditiously as possible, but no later than seventy-two (72) hours after receiving the request.

Member Grievances

Who can file a grievance?

A grievance may be filed by any of the following:

- You may file a grievance.
- Someone else may file the grievance for you on your behalf. You may appoint an individual to act as your representative to file the grievance for you by following the steps below:
  - — Provide SecureHorizons with your name, your Medicare number, and a statement which appoints an individual as your representative. (**Note:** You may appoint a physician or a Provider.) For example: "I _____ *[your name]* appoint _____ *[name of representative]* to act as my representative in requesting a grievance from SecureHorizons and/or CMS regarding the denial or discontinuation of medical services."
  - — You must sign and date the statement.
  - — Your representative must also sign and date this statement.
  - — You must include this signed statement with your grievance.

What is a grievance?

A grievance is a type of complaint you make if you have a complaint or problem that does not involve payment or services by SecureHorizons or a Contracting Medical Provider. For example, you would file a grievance if you have a problem with things such as the quality of your care, general dissatisfaction with the way MedicareComplete® Retiree Plan benefits are designed, waiting times for appointments or in the waiting room, the way your doctors or others behave, not being able to reach someone by phone or obtain the information you need, or lack of cleanliness or the condition of the doctor's office.

When can a grievance be filed?

You may file a grievance within sixty (60) calendar days of the date of the circumstance giving rise to the grievance. There is no filing limit for complaints concerning quality of care.

Note: The sixty (60)-day limit may be extended for good cause. Include in your written request the reason why you could not file within the sixty (60)-day timeframe.

Expedited Grievance

You have the right to request a fast review or expedited grievance if you disagree with the SecureHorizons decision to invoke an extension on your request for an organization determination or reconsideration, or the SecureHorizons decision to process your expedited request as a standard request. In such cases, SecureHorizons will acknowledge your grievance within twenty-four (24) hours of receipt and notify you in writing of the SecureHorizons conclusion within three (3) calendar days.

Where can a grievance be filed?

A grievance may be filed in writing directly to SecureHorizons Appeals and Grievance Unit at P.O. Box 6006, Cypress, CA 90630, Mailstop CA124-0157 or

a. You may contact Customer Service at 1-866-622-8055 (TTY 1-888-685-8480), 8 a.m. to 8 p.m. local time, Monday through Sunday.

b. You may fax your request to 1-800-346-0930.

Why file a grievance?

You are encouraged to use the grievance procedure when you have any type of complaint (other than an appeal) with SecureHorizons or a Contracting Medical Provider, especially if such complaints result from misinformation, misunderstanding or lack of information.

The above Medicare Advantage plans are offered by any of the following: UnitedHealthcare Insurance Company and its affiliated companies ("UnitedHealthcare"), Medicare Advantage Organizations with a Medicare contract.

MedicareComplete Part D Prescription Drug Appeals and Grievances Process

Member Appeals

An Appeal is a type of complaint you make when you want a redetermination and a change to a decision (Coverage Determination) we have made about what drugs are covered under your MedicareComplete Retiree Plan or what we will pay for a drug. You may also make a complaint if you disagree with a decision to stop coverage that you are receiving.

You, or your appointed representative, may request a redetermination (Appeal) of an unfavorable Coverage Determination related to a Part D prescription drug. You may also Appeal the following situations:

- When a Coverage Determination is not provided in a timely manner.
- When a delay in a Coverage Determination would adversely affect your health.
- When a decision has been made that you do not meet the criteria for a Formulary exception.
- When a decision has been made that you do not meet the criteria for a copayment or coinsurance exception.

MedicareComplete Retiree Plan Medicare Part D Appeal Timeframes:

- **Standard Appeals must be completed within seven (7) calendar days or sooner if your health requires.**
- **Expedited Appeals must be completed within seventy-two (72) hours.**
- **Extensions to timeframes are not permitted.**

The first level of Appeal is considered a **redetermination** by the Centers for Medicare & Medicaid Services (CMS). The redetermination process is required to be completed within seven (7) calendar days of our receipt of the request, or sooner if your health requires. You must submit a written request for a redetermination to the Part D Prescription Appeals & Grievance Department at P.O. Box 6006, Cypress, CA 90630, Mailstop: CA 124-0157, or you may fax your written request to 1-800-346-0930. You must submit your written request within sixty (60) calendar days of the date of the notice of the initial coverage determination.

You are not required to submit additional information to support your request for a reconsideration (Appeal). We are responsible for gathering all necessary medical information. However, it may be helpful to include additional information to clarify or support your request. For example, you may want to include information in your Appeal request, such as medical records or physician opinions in support of your request.

Note: The sixty (60) calendar day limit may be extended for good cause. Include in your written request the reason you could not file within the sixty (60) calendar day timeframe.

We will conduct a redetermination and notify you in writing of the decision within seven (7) calendar days from the receipt of your request. Our reconsideration decision will be made by a person or persons not involved in the initial decision.

If we reverse the original adverse decision, we must authorize or provide coverage as expeditiously as your health requires, but no later than seven (7) calendar days from the date your request for an Appeal was received; or pay your claim within thirty (30) calendar days from the date your request for an Appeal was received.

If the redetermination is not completed within the required timeframe, we must submit the request to an Independent Review Entity (IRE) for review.

If you remain dissatisfied after the redetermination, you may request a further review known as a **reconsideration.** The reconsideration will be performed by the IRE. You, or your appointed representative, may request a reconsideration by the IRE within sixty (60) calendar days of receiving an adverse determination on a redetermination review.

The IRE will notify us that you have filed a reconsideration request. CMS requires the IRE to issue its reconsideration decision within seven (7) calendar days for a standard reconsideration, and within seventy-two (72) hours for expedited requests.

If the IRE maintains the denial, its notice will inform you of your right to a hearing before an Administrative Law Judge (ALJ). You may request a hearing before an ALJ by submitting a written request to the entity specified in the IRE's reconsideration notice. The request must be made within sixty (60) calendar days of the date of the IRE's notice that the reconsideration decision was not in your favor. A hearing can be held only if the amount in controversy is equal to or greater than $100 plus the percentage increase in the medical care component of the Consumer Price Index, as measured from July 2003 to the July preceding the current year involved rounded to the nearest multiple of $10. The Administrative Law Judge will not review your appeal if the dollar value of the contested Part D benefit does not meet the minimum requirement provided in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

If we have refused to provide Part D prescription drug benefits, the dollar value for requesting an Administrative Law Judge hearing is based on the projected value of those benefits. The projected value includes any costs you could incur based on the number of refills prescribed for the requested drug during the plan year. Projected value includes your copayments, all costs incurred after your costs exceed the initial coverage limit, and costs paid by other entities.

You may also combine multiple Part D claims to meet the dollar value if:

1. The claims involve the delivery of Part D prescription drugs to you;
2. All of the claims have received a determination by the independent review organization as described above;
3. Each of the combined requests for review is filed **in writing** within 60 calendar days after the date that each decision was made; and
4. Your hearing request identifies all of the claims to be heard by the Administrative Law Judge.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor:

The Administrative Law Judge will tell you in writing about his or her decision and the reasons for it. What happens next depends on the type of appeal:

- For a decision about **payment** for a Part D drug you already received. We must send payment to you no later that 30 calendar days from the date we receive the determination.
- **For a standard decision about a Part D drug you have not received.** We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive the determination.
- **For a fast decision about a Part D drug you have not received.** We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive the determination.

If the Judge rules against you:

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council. The letter you get from the Administrative Law Judge will tell you how to request this review.

If you are dissatisfied with an ALJ hearing decision, you may request a Medicare Appeals Council (MAC) review, which may either review the decision or decline to review. The notice you receive from the Administrative Law Judge will inform you how to request this review.

The Medicare Appeals Council (MAC) will first decide whether to review your case or not. There is no minimum dollar value for the MAC to hear your case. If you received a denial letter from the ALJ, you or your appointed representative can request a review by filing a written request from the Council.

The MAC does not review every case. If they decide not to review your case, **then** you may request a review by a Federal Court Judge. The MAC will issue a written notice advising you of any action taken with respect to your request for review. The notice will inform you how to request a review by a Federal Court Judge. If the MAC reviews your case, they will make a decision as soon as possible.

If the Council decides in your favor, it will notify you in writing of its decision. We will provide payment or authorization in the following timeframes:

- For a decision about payment for a Part D drug you have already received, we must send payment to you no later than thirty (30) calendar days from the date we receive the determination.
- For a standard decision about a Part D drug you have not received, we must authorize or provide you with the Part D drug you have requested within 72 hours from the date we receive the determination.
- For an expedited decision about a Part D drug you have not received, we must authorize or provide you with the Part D drug you have requested within 24 hours from the date we receive the determination.

If the Council maintains the denial, it will notify you in writing of its decision. You have the right to continue your appeal by asking a Federal Court Judge to review the case.

You may also request a judicial review of the ALJ's decision if the MAC denied your request for review, and the amount involved is equal to or greater than $1,000 plus the percentage increase in the medical care component of the Consumer Price Index, as measured from July 2003 to the July preceding the current year involved. If the amount involved meets the minimum requirement provided in the Medicare Appeals Council's decision, you have the right to continue your appeal by asking a Federal Court Judge to review the case. If the value is less than the minimum requirement, the Council's decision is final and you may not take the appeal any further. The MAC will send you a written notice advising you of any action taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Judge make a decision?

The federal judiciary is in control of the timing of any decision.

If the Judge decides in your favor:

Once we get notice of a judicial decision in your favor, what happens next depends on the type of appeal:

1. **For a decision about payment for a Part D drug you already received.** We must send payment to you within 30 calendar days from the date we get notice reversing our coverage determination.
2. **For a standard decision about a Part D drug you have not received.** We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our coverage determination.
3. **For a fast decision about a Part D drug you have not received.** We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our coverage determination.

If the Judge decides against you:

The Judge's decision is final and you may not take the appeal any further.

The following are not considered Coverage Determinations and do not constitute the right to Appeal:

- **Transactions at the pharmacy counter are not Coverage Determinations.**
- **Information on a benefit plan design as it pertains to all members is not a Coverage Determination.**
- **The decision to place a drug on a Prior Authorization list is not a Coverage Determination and is not subject to Appeal.**

Expedited/72-Hour Appeal Procedures

You have the right to request and receive an expedited seventy-two (72)-hour redetermination (Appeal) in situations in which waiting for a redetermination (Appeal) decision to be made within the standard timeframe could seriously jeopardize your life, health, or your ability to regain maximum function. If we decide, based on medical criteria, that your situation is Time-Sensitive, or if your prescribing doctor calls or writes in support of your request for an expedited redetermination (Appeal) review, we will issue a decision as expeditiously as possible, but no later than seventy-two (72) hours after receiving the request.

How To Request an Expedited Appeal

To request an expedited seventy-two (72)-hour review, you or your authorized representative may call, write, fax or visit SecureHorizons. **Be sure to ask for an expedited seventy-two (72)-hour review when you make your request.**

Call: 1-866-622-8055
8 a.m. to 8 p.m. local time
Monday through Sunday
We will document your request in writing.

TTY: 1-888-685-8480
8 a.m. to 8 p.m. local time
Monday through Sunday
We will document your request in writing.

Write: SecureHorizons Part D Prescription Appeals and Grievance Department
P.O. Box 6006
Cypress, CA 90630
Mailstop: CA124-0157

Fax: Coverage Determinations
1-800-346-0930
Attention: Part D Prescription Appeals and Grievance Department

Note: The Appeals and Grievance Department will record the date and time of all telephone or fax requests for expedited seventy-two (72)-hour reviews received on Saturday or Sunday or before or after business hours, Monday through Friday. The seventy-two (72)-hour period for the expedited review will begin at the time received.

Upon receiving your redetermination request, we will determine if your request meets the definition of Time-Sensitive. Requests for redeterminations that include a doctor's support will automatically be treated as an expedited Appeal.

If your request does not meet the definition of Time-Sensitive, it will be handled within the standard review process of seven (7) calendar days. You will be informed by telephone that your request for the expedited seventy-two (72)-hour review has been denied, and we will send a written confirmation within three (3) calendar days of the telephone call that the request will be processed within the standard review timeframe. If you disagree with our decision to process your request within the standard timeframe, you may file a Grievance with us. The written confirmation letter will include instructions on how to file a Grievance. If you have requested a fast decision, you will be notified of our Appeal decision within seventy-two (72) hours. We will send a follow-up decision letter within three (3) calendar days of the telephone call.

Member Grievances

A Grievance is a type of complaint that you make about us or one of our Plan providers, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Grievance Procedures

If you have a grievance, we encourage you to first call Customer Service. We will try to resolve any complaint that you might have over the phone. If you request a written response to your phone complaint, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this our Formal Grievance process. This process is required to be complete within thirty (30) calendar days of our receipt of request.

You may submit a written request for a grievance to the Part D Appeals and Grievance Department at P.O. Box 6006, Cypress, CA 90630, Mailstop: CA124-0157, or

You may fax your written request to 1-800-346-0930.

You must submit your written request within sixty (60) calendar days of the date of the incident.

Note: The sixty (60)-day limit may be extended for good cause. Include in your written request the reason why you could not file within the sixty (60)-day timeframe.

We must notify you of our decision about your grievance as quickly as your case requires, based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the timeframe by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

Asking for a "Fast" Grievance Determination

Do you have a request for a Part D prescription drug coverage determination or redetermination that needs to be decided more quickly than the standard timeframe? If you disagree with our decision not to expedite your request for an expedited coverage determination or redetermination, you may request an expedited or "fast" grievance. If you disagree with our decision to process your request within the standard timeframe, you may file an expedited grievance with us. The written confirmation letter will include instructions on how to file an expedited or "fast" Grievance.

How to request a Fast Grievance Determination

You may submit a written request for a Fast Grievance to the Part D Appeals and Grievance Department at:

SecureHorizons Appeals and Grievance Unit
P.O. Box 6006
Cypress, CA 90630
Mailstop: CA124-0157

or

You may fax your written request to 1-800-346-0930.

You may call us to file an expedited grievance at:

1-866-622-8055
24 hours a day, 7 days a week.

TTY: 1-888-685-8480

Please be sure to include the words "Fast," "Expedited" or "24-hour review" on your request.

Complaints Involving Quality of Care Issues

All complaints that involve quality of care issues are referred to SecureHorizons' Health Services Department for review. Complaints that affect an enrollee's immediate condition will receive immediate review. We will investigate the complaint with the involved providers and appropriate departments. You may need to sign an authorization to release your medical records. We will confirm receipt of your complaint within thirty (30) calendar days of receiving your complaint. The results of the Quality Management review are confidential.

For quality of care complaints, you may also complain to the Quality Improvement Organization (QIO)

Complaints concerning the quality of care received under Medicare may be acted upon by the Medicare prescription drug plan under the grievance process, by an independent organization called the QIO, or by both. For example, if an enrollee believes his/her pharmacist provided the incorrect dose of a prescription, the enrollee may file a complaint with the QIO in addition to or in lieu of a complaint filed under the Part D plan's grievance process. For any complaint filed with the QIO, the Part D plan must cooperate with the QIO in resolving the complaint. For the QIO contact information in your area, please refer to Exhibit B of your Evidence of Coverage.

How to file a quality of care complaint with the QIO

Quality of care complaints filed with the QIO must be made in writing. An enrollee who files a quality of care grievance with a QIO is not required to file the grievance within a specific time period. See the Evidence of Coverage for more information about how to file a quality of care complaint with the QIO.

Extra Help With Your Covered Drug Costs

If you are a MedicareComplete Retiree Plan member with limited income and resources, you may be eligible to get extra help paying for your Medicare Part D prescription drug costs. Members with the lowest income and resources are eligible for the most help. If you are qualified for extra help with your drug costs, your costs for Formulary drugs will be different than the copayments and coinsurance amounts listed in the Summary of Benefits and the Schedule of Benefits.

Certain members of MedicareComplete Retiree Plan may automatically be eligible for help with the cost of Medicare Part D premiums (if applicable), copayments and coinsurance and will not need to apply. Members who are automatically eligible include members:

- who are currently receiving both Medicare and Medicaid benefits, with prescription drug coverage.
- who receive both Medicare and Supplemental Social Security (SSI) benefits.
- whose Medicare premiums are paid by a state Medicaid program.

Other members, who do not qualify under the above programs, but who also have limited resources and income, must apply for help.

Once you qualify for extra help with your Medicare Part D prescription drug costs, we will send you a Low Income Subsidy Evidence of Coverage Rider, which will explain the reduced Medicare Part D Premium (if applicable), copayments and coinsurance you will pay for your prescription drugs.

How To Find Out About Low Income and Resources Assistance

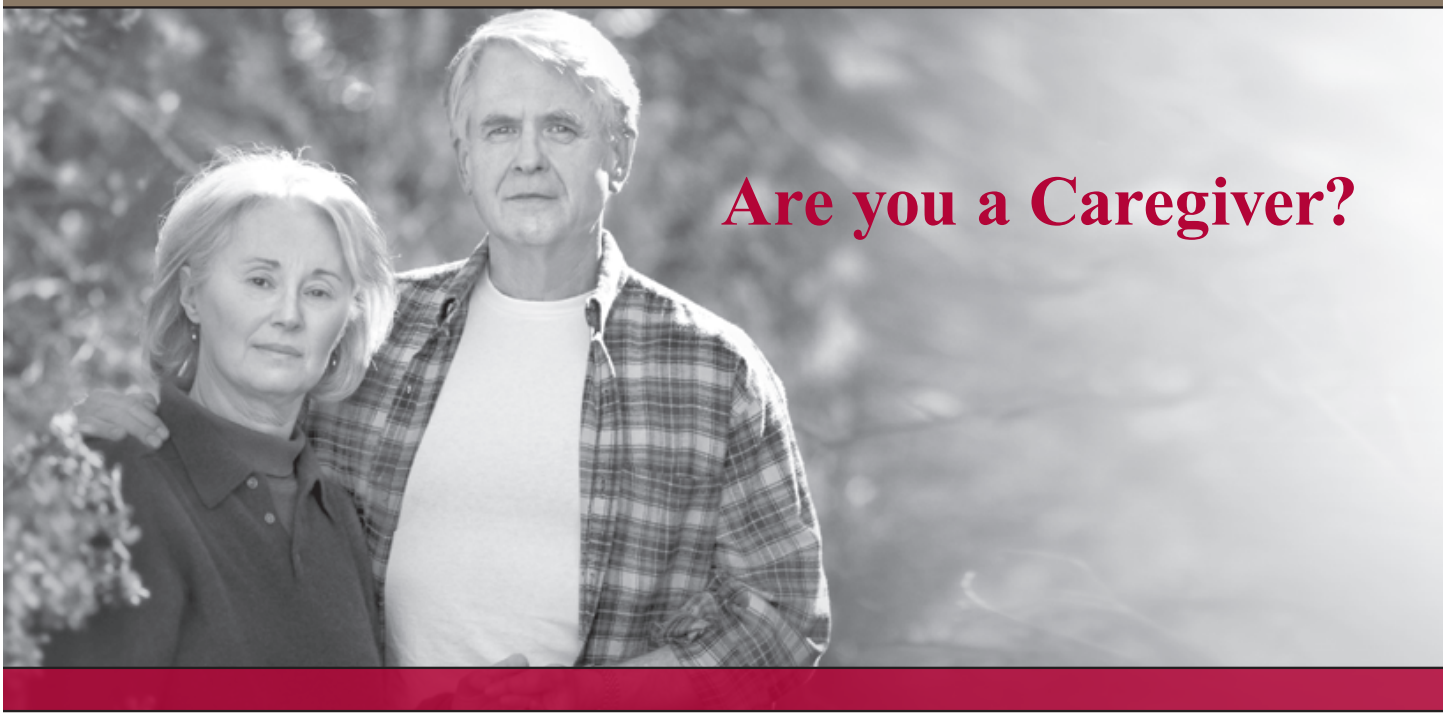
We have contracted with Social Service Coordinators to offer MedicareComplete Retiree Plan members no-cost assistance with the application process. If you have any questions, you may contact Social Service Coordinators at 1-888-528-9488 (TTY 1-877-644-3244), 9 a.m. to 8 p.m. EST, Monday through Friday, and speak to a representative who will determine if you may be eligible for assistance.

Please call Customer Service at 1-866-622-8055 (TTY 1-888-685-8480), 8 a.m. to 8 p.m. local time, Monday through Sunday, for more information. You may also contact your local State Medicaid Agency or the Social Security Administration for more information or assistance. You can obtain the local number for your State Agency by calling 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048), 24 hours a day, 7 days a week. The Social Security Administration is available at 1-800-772-1213 (TTY 1-800-325-0778), 7 a.m. to 7 p.m. PST, Monday through Friday.

How does your prescription drug coverage work if you go to a hospital or skilled nursing facility?

If you are admitted to a hospital for a Medicare-covered stay, Medicare Part A will cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, we will cover your Medicare Part D prescription drugs as long as all coverage requirements are met (such as the drugs being on our Formulary, filled at a network pharmacy, etc.)

If you are admitted to a skilled nursing facility for a Medicare-covered stay, after Medicare Part A stops paying for your prescription drug costs, we will cover your Medicare Part D prescription drugs as long as the drug meets all of our coverage requirements and the drug would not otherwise be covered by Medicare Part B coverage. When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period, during which time you will be able to leave this Plan and join a new Medicare Prescription Drug Plan. (See the Evidence of Coverage for information on enrollment periods.)



Do you care for a loved one or does someone care for you?

- ✔ Do you help your spouse or need help with daily tasks such as bathing, dressing or taking medication?
- ✔ Do you help your parent get to and from the drugstore or doctor's office?
- ✔ Are you concerned that your loved one or you may not be able to remain independent?
- ✔ Do you feel overwhelmed, alone and don't know where to turn for help?

If you are one of 44 million Americans who is a caregiver or if someone is caring for you, Evercare™ Solutions for Caregivers can help. To learn more about our personalized approach to caregiving and how it may benefit you and your loved one, read on.

Evercare™
Solutions for Caregivers

www.EvercareHealthPlans.com/Caregiver

How Can Solutions for Caregivers Help Me?

You've been looking forward to a carefree retirement, but instead you've taken on a new and even more demanding job – caring for a spouse or loved one. Thanks to **Solutions for Caregivers,** there's help. This ground-breaking program is available to you through your former employer's group retiree program with Evercare, a division of UnitedHealth Group.

In-Person Professional Care Manager Services

- Up to six hours of Professional Care Management, through a contracted nationwide network, per eligibility year.
- Personalized in-home assessment along with a comprehensive plan of care available to you and your spouse or other adult loved one.
- Help finding and coordinating local support services that meet the needs of both the caregiver and aging loved one.
- Review of alternate living accommodations plus move coordination when necessary.

Elder Law Referral and Services

- Access to contracted nationwide network of Elder Law attorneys for you, your spouse or other aging loved one under your care.
- Up to two cost-free hours of consultation on four Elder Law topics per eligibility year.
- Cost-free preparation of four Simple Wills and four Living Wills related per eligibility year.
- Consultation and preparation (if needed) of up to four of the following documents (for a $35 per document fee paid directly to the attorney) per eligibility year.
  – Durable Power of Attorney
  – Financial Durable Power of Attorney
  – Health Care Durable Power of Attorney
  – Health Care Directive

Unlimited Telephonic Support

- Provide centralized toll-free telephonic support 24 hours a day, 7 days a week.
- Conduct timesaving, personalized research by identifying local resources and services that fit your caregiving needs.
- Coach you on how to deal with family issues and the stress of caregiving.

Peace of mind is just a phone call away. Let us help you.

For general questions prior to enrollment, call 1-800-610-2660, or for the hearing impaired, 1-800-387-1074, 8 a.m. to 8 p.m. Local Time, Monday through Sunday.

Evercare® plans are offered by UnitedHealthcare Insurance Company, or one or more of its affiliated companies (including PacifiCare,® PacifiCare of Colorado, Inc., Evercare of Texas, LLC, and Oxford licensed HMOs and insurance companies).

Evercare™
Solutions for Caregivers

RTCGFLY07 SHCA040011-000

The SilverSneakers® Fitness Program

Enroll in the **SilverSneakers® Fitness Program** to help promote better health and maintain your independence. SilverSneakers is **available at no additional cost** for all Arizona State Retirement System retired members and dependents enrolled in ASRS medical plan!

The SilverSneakers Fitness Program

As the nation's leading exercise program designed exclusively for older adults, SilverSneakers includes a basic fitness center membership *(see list on next page)*, specialized SilverSneakers classes, Senior Advisor℠ assistance and much more!

SilverSneakers Steps

If you live outside the areas listed for the SilverSneakers Fitness Program, increase your physical activity by joining **SilverSneakers® Steps**, a self-directed, pedometer-based walking and exercise program.

PRIME

Members age 50 to 64 can participate in this innovative, exciting program that will help you manage your health and well-being at no additional cost. Visit our website, www.primemember.com, for more information.

For more information about SilverSneakers or SilverSneakers Steps, log on to **www.silversneakers.com**.

Participating SilverSneakers Locations

Ahwatukee/Foothills
Ahwatukee Foothills YMCA
1030 E. Liberty Ln.
480-759-6762
Amenities: E, P, SC

Apache Junction
Apache Junction Multigenerational Center
1035 N. Idaho Rd.
480-474-5240
Amenities: E, SC

Bullhead City
Mad Dog Fitness
2350 Miracle Mile Dr., Ste. 370
928-704-7717
Amenities: E, SC

Casa Grande
Casa Grande Fitness & Racquet Club
2080 N. Trekell Rd.
520-836-0613
Amenities: E, S, W, SC

Chandler
Chandler-Gilbert Community College - Pecos Campus
2626 E. Pecos Rd.
480-732-7200
Amenities: E, SC

Fitness Forum
2130 W. Chandler Blvd.
480-812-0200
Amenities: E, S, P, W, SC

Cottonwood
Valley Athletic Club
904 N. Main St.
928-634-9886
Amenities: E, S, SC

Flagstaff
Flagstaff Athletic Club
3200 N. Country Club Dr.
928-526-8652
Amenities: E, S, P, W, SC

Fountain Hills
Anytime Fitness - Fountain Hills
16650 E. Palisades Blvd.
Ste. 109
480-837-5151
Amenities: E, SC

Participating SilverSneakers Locations

Gilbert
Fitness Works - Gilbert
1668 N. Higley Rd.
480-396-0086
Amenities: E, S, P, W, SC

Glendale
Glendale Community College
Fitness Center
6000 W. Olive Ave.
623-845-3801
Amenities: E, P*, SC

Glendale/Peoria YMCA
14711 N. 59th Ave.
602-588-9622
Amenities: E, P, SC

Goodyear
Infinity Fitness Center
255 N. Litchfield Rd.
623-882-3700
Amenities: E, SC

Southwest Valley Regional YMCA
2919 N. Litchfield Rd.
623-935-5193
Amenities: E, P, SC

Green Valley
Independent Lifestyle Fitness Center
630 W. Ward Lane
Ste. 132 & 142
520-625-9649
Amenities: SC

Lake Havasu City
London Bridge Racquet & Fitness Club
1407 McCulloch Blvd.
928-855-6274
Amenities: E, S, P, W, SC

Maricopa
Anytime Fitness - Maricopa
20924 N. John Wayne Pkwy.
Ste. D-4
520-568-5226
Amenities: E, SC

Mesa
Bally Total Fitness - Mesa
1350 S. Longmore Rd.
480-844-7227
Amenities: E, SC

Fitness Works
6040 E. Brown Rd.
480-807-5080
Amenities: E, S, P, W, SC

Golden's Family Fitness
931 S. Gilbert Rd.
480-497-9989
Amenities: E, S, P, W, SC

Mesa Family YMCA
207 N. Mesa Dr.
480-969-8166
Amenities: E, P, SC

Red Mountain Multigenerational Center
7550 E. Adobe
480-644-4810
Amenities: E, SC

Nogales
Fitness Express
2051 N. Grand Ave.
520-761-4820
Amenities: E, SC

Payson
Payson Athletic Club
400 E. Hwy. 260 Ste. F
928-474-0916
Amenities: E, SC

Peoria
Fitness One
9028 W. Union Hills Dr., Ste. 1
623-376-7888
Amenities: E, SC

Phoenix
Bally Total Fitness - Cave Creek
12235 N. Cave Creek Rd.
602-482-1151
Amenities: E, S, P, W, SC

Phoenix (cont.)
Bally Total Fitness - Estes
15401 N. 29th Ave.
Arizona Business Park
602-993-3366
Amenities: E, S, P, W, SC

Bally Total Fitness - Indian School
3921 E. Indian School Rd.
602-956-4116
Amenities: E, SC

Chris-Town YMCA
5517 N. 17th Ave.
602-242-7717
Amenities: E, P, SC

Fitness West
6850 W. Indian School Rd.
623-846-6884
Amenities: E, S, P, W, SC

Lincoln Family Phoenix Downtown YMCA
350 N. 1st Ave.
602-257-5138
Amenities: E, S, P, W, SC

Paradise Valley Community College Fitness Center
18401 N. 32nd St.
602-787-7270
Amenities: E, SC

Phantom Horse Athletic Club
7777 S. Pointe Pkwy.
602-431-6484
Amenities: E, S, P, W, SC

Phoenix College Fitness Center
1202 W. Thomas Rd.
602-285-7646
Amenities: E, SC

South Mountain YMCA
222 E. Olympic Dr.
602-276-4246
Amenities: E, P, SC

Phoenix (cont.)
The Family Life Center
5757 N. Central Ave.
602-707-5903
Amenities: E, S, SC
Located on the campus of North Phoenix Baptist Church

Prescott
Prescott Downtown Athletic Club
130 N. Cortez
928-445-0204
Amenities: E, S, W, SC

Prescott Valley
Anytime Fitness - Prescott Valley
6715 E. 2nd St., Ste. A
928-443-5701
Amenities: E, SC

Queen Creek
Copper Basin YMCA
28300 N. Main St.
480-882-2242
Amenities: E, P, W, SC

Scottsdale
Scottsdale Community College
Fitness Center
9000 E. Chaparral Rd.
480-423-6604
Amenities: E, SC

Scottsdale/Paradise Valley YMCA
6869 E. Shea Blvd.
480-951-9622
Amenities: E, P, SC

Sedona
Sedona Community Center
2615 Melody Ln.
928-282-2834
Amenities: SC

Sierra Vista
Cochise Health & Racquet Club
4225 Avenida Cochise
520-458-7075
Amenities: E, S, P*, W, SC

Sun LakesMaxLife
24210 S. Oakwood Blvd.
480-802-6853
Amenities: E, S, P, W, SC

Surprise
Fitness One
16630 W. Greenway Rd.
Ste. 307
623-594-4887
Amenities: E, SC

Fitness One
12851 W. Bell Rd., Ste. 22
623-977-7588
Amenities: E, SC

Tempe
Tempe YMCA
7070 S. Rural Rd.
480-730-0240
Amenities: E, P, W, SC

Tucson
Arizona Swim and Fitness
1290 W. Prince
520-408-2888
Amenities: E, S, P, W, SC

Bally Total Fitness - Tucson
4690 N. Oracle Rd. #100
520-293-2330
Amenities: E, P, W, SC

Desert Sports & Fitness
3672 S. 16th Ave.
520-791-7799
Amenities: E, SC

Desert Sports & Fitness
2480 N. Pantano Rd.
520-722-6300
Amenities: E, S, P, W, SC

FIT at the River
4892 N. Stone Ave., Ste. 160
520-690-9299
Amenities: E, SC

FitCenter
5555 E. 5th St.
520-571-7000
Amenities: E, S, P, W, SC

Tucson (cont.)
Gold's Gym Northwest
7315 N. Oracle Rd.
520-297-8000
Amenities: E, S, P, W, SC

Highlands Mobile Home Estate Clubhouse
332 W. Matterhorn
520-297-2722
Amenities: SC

Lighthouse/City YMCA
2900 N. Columbus Blvd.
520-795-9725
Amenities: E, P, W, SC

Lohse Family YMCA
60 W. Alameda St.
520-623-5200
Amenities: E, S, P, W, SC

Mid-Valley Athletic Club
140 S. Tucson Blvd.
520-792-3654
Amenities: E, S, P, W, SC

Northwest Family YMCA
7770 N. Shannon Rd.
520-229-9001
Amenities: E, P, SC

Ott Family YMCA
401 S. Prudence
520-885-2317
Amenities: E, P, W, SC

Tucson Jewish Community Center
3800 E. River Rd.
520-299-3000
Amenities: E, S, P, W, SC

Amenities Legend

E	**Exercise Equipment**
S	**Steam/Sauna**
P	**Pool**
W	**Whirlpool**
SC	**SilverSneakers Classes**

Notes

Notes

Notes

Customer Service
1-866-622-8055
TTY 1-888-685-8480
8 a.m. to 8 p.m. local time
Monday through Sunday

www.pacificare.com/adoa

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